United States Virgin Island

Eligible Hospital EHR Incentive Program Application Manual

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Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Molina Healthcare. It is healthcare data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Version	Date	Author	Action/Summary of Changes	Status
1.0	1/16/15	Karla Battle	Submitted to USVI for review after modifying for the 2013 and 2014 CMS changes	Active

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1. Introduction

The Electronic Health Records (EHR) Incentive Payment is a federal program offering financial support to assist eligible providers to adopt, implement, and upgrade certified EHR technology or meaningful use of an EHR system. The federal program defines the options as follows.

- Adopt: to acquire and install a certified EHR technology,
- Implement: to train staff, deploy tools, exchange data,
- Upgrade: to expand functionality or interoperability
- Meaningful Use: to display that the EHR is being used to positively affect the care of the patient.

The program goals are to improve outcomes, facilitate access, simplify care, and reduce costs of healthcare nationwide by:

- Enhancing care coordination and patient safety
- Reducing paperwork and improving efficiencies
- Facilitating information sharing across providers, payers, and state lines
- Enabling communication of health information to authorized users through state Health Information Exchange (HIE) and the National Health Information Network (NHIN).

Incentives will be available through both Medicaid and Medicare. Hospitals may be able to receive incentive payments for both programs. The Department of Health Services (DHS) will administer the Medicaid EHR Incentive Payment for USVI using an application called USVI Medicaid EHR Incentive Program.

1.1 Eligible Hospitals

To be eligible for the USVI Medicaid EHR Incentive Program, a hospital must be actively enrolled with USVI Medicaid and fall into one of the following categories:

Acute Care Hospitals

- Includes general hospitals, cancer hospitals and critical access hospitals;
- Must have a CMS Certification Number (CCN) with the last four digits in the series 0001 – 0879 and 1300-1399;
- Must have an average length of patient stay of 25 days or fewer;
- Must have 10% Medicaid Patient Volume based on encounters.

Children's Hospitals

- Must have a CMS Certification Number (CCN) with the last four digits in the series 3300-3399;

- No average length of stay or patient volume requirements

A hospital must also be either actively enrolled with Medicaid as an acute care hospital, (including critical access hospitals or cancer hospitals) or a Medicaid enrolled children's hospital.

Eligible Hospitals are able to attest for Fiscal Year (FY) 2014 or 2015. Below is the attestation schedule for volume and EHR Certifications checks for each year.

Attesting for FY 2014

- If Dual-Eligible, EH must attest for Medicare First, then Medicaid.
- Claims Volume check will be 90 days in FY 2013.
- EHR Certification check will be 90 days in FY 2014.

Attesting for FY 2015

- If Dual-Eligible, EH must attest for Medicare First, then Medicaid.
- Claims Volume check will be 90 days in FY 2014.
- EHR Certification check will be 90 days in FY 2015.

1.2 Registering with CMS

Prior to participating in the USVI Medicaid EHR Incentive program, an eligible hospital first must be registered for the **EHR Incentive Program** within the CMS National Level Repository(NLR) system to sign up for the program at the national level and must select either **"Medicaid" or "dual-eligible"** as its desired payment path and **"USVI"** as its assigned state for attestation. This will enable the CMS NLR solution to notify the USVI Medicaid EHR Incentive Payment application of the hospital's intent to attest for incentive payment. Visit the National Level Repository (NLR) solution at https://ehrincentives.cms.gov/hitech/login.action to register.

Once the hospital has successfully registered with the CMS NLR for the USVI Medicaid EHR Incentive Program, they must complete the attestation for the year with the **USVI Medicaid EHR Incentive Payment** solution available by logging into the secure Medicaid Provider web portal www.vimmis.com **after waiting at minimum 48 hours** for incentive registration to be processed and be received by USVI Medicaid EHR Incentive program application from the NLR. Hospitals who do not have access to the web portal can request access via an online form at https:// www.vimmis.com

NOTE: If the provider wishes to receive any of the attestation update e-mails from the USVI Medicaid EHR Incentive Program application, the provider must add the email address to the

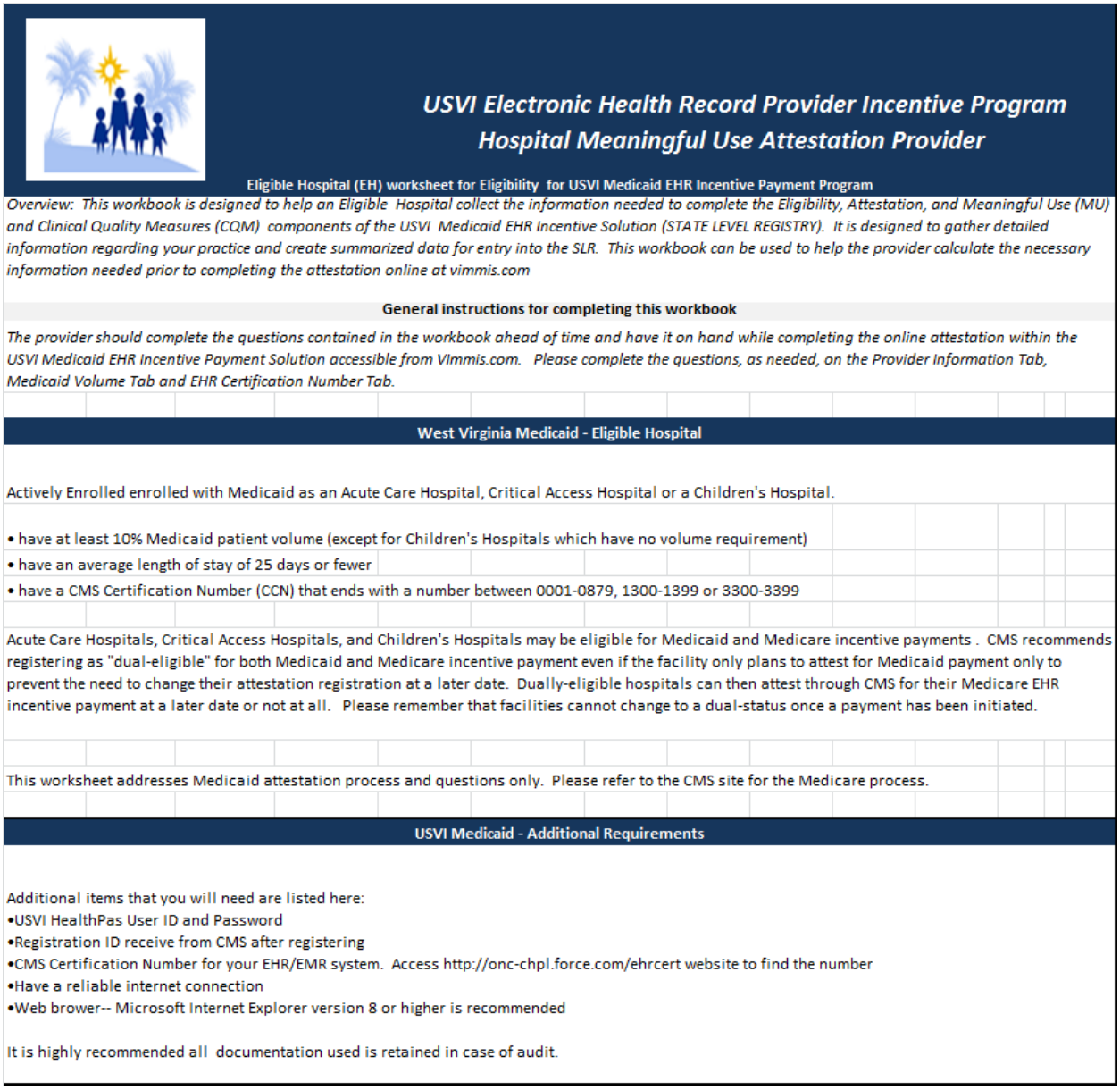
CMS registration information. The USVI Medicaid EHR Incentive Program solution will send emails to this address as the attestation status changes during the attestation process..

2. Information Needed

Before a hospital can begin to complete the USVI Medicaid EHR Incentive Program attestation, the hospital will need to gather all of the information necessary to complete the attestation correctly. The USVI Medicaid EHR Incentive program has created a workbook to guide the hospital user through the data needed to complete an attestation successfully. The workbook is available in PDF format. This workbook is also embedded within this User Manual in the immediate pages below as well as available on the vimmis.com portal. The Eligible Hospital Workbook provides the questions that CMS requires for their registration process and that the EHR Incentive Program Attestation Application requires for the USVI attestation process. The Workbook can be used to gather answers before logging in to the USVI Medicaid EHR Incentive Program Attestation Application.

2.1 Eligible Hospital Attestation Workbook - Overview

The first tab of the workbook describes the eligibility requirements for the professional provider and web requirements for utilizing the USVI Medicaid EHR Incentive payment program application.



USVI Electronic Health Record Provider Incentive Program
Hospital Meaningful Use Attestation Provider

Eligible Hospital (EH) worksheet for Eligibility for USVI Medicaid EHR Incentive Payment Program

Overview: This workbook is designed to help an Eligible Hospital collect the information needed to complete the Eligibility, Attestation, and Meaningful Use (MU) and Clinical Quality Measures (CQM) components of the USVI Medicaid EHR Incentive Solution (STATE LEVEL REGISTRY). It is designed to gather detailed information regarding your practice and create summarized data for entry into the SLR. This workbook can be used to help the provider calculate the necessary information needed prior to completing the attestation online at vimmis.com

General instructions for completing this workbook

The provider should complete the questions contained in the workbook ahead of time and have it on hand while completing the online attestation within the USVI Medicaid EHR Incentive Payment Solution accessible from VImmis.com. Please complete the questions, as needed, on the Provider Information Tab, Medicaid Volume Tab and EHR Certification Number Tab.

West Virginia Medicaid - Eligible Hospital

Actively Enrolled enrolled with Medicaid as an Acute Care Hospital, Critical Access Hospital or a Children's Hospital.

- have at least 10% Medicaid patient volume (except for Children's Hospitals which have no volume requirement)
- have an average length of stay of 25 days or fewer
- have a CMS Certification Number (CCN) that ends with a number between 0001-0879, 1300-1399 or 3300-3399

Acute Care Hospitals, Critical Access Hospitals, and Children's Hospitals may be eligible for Medicaid and Medicare incentive payments . CMS recommends registering as "dual-eligible" for both Medicaid and Medicare incentive payment even if the facility only plans to attest for Medicaid payment only to prevent the need to change their attestation registration at a later date. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date or not at all. Please remember that facilities cannot change to a dual-status once a payment has been initiated.

This worksheet addresses Medicaid attestation process and questions only. Please refer to the CMS site for the Medicare process.

USVI Medicaid - Additional Requirements

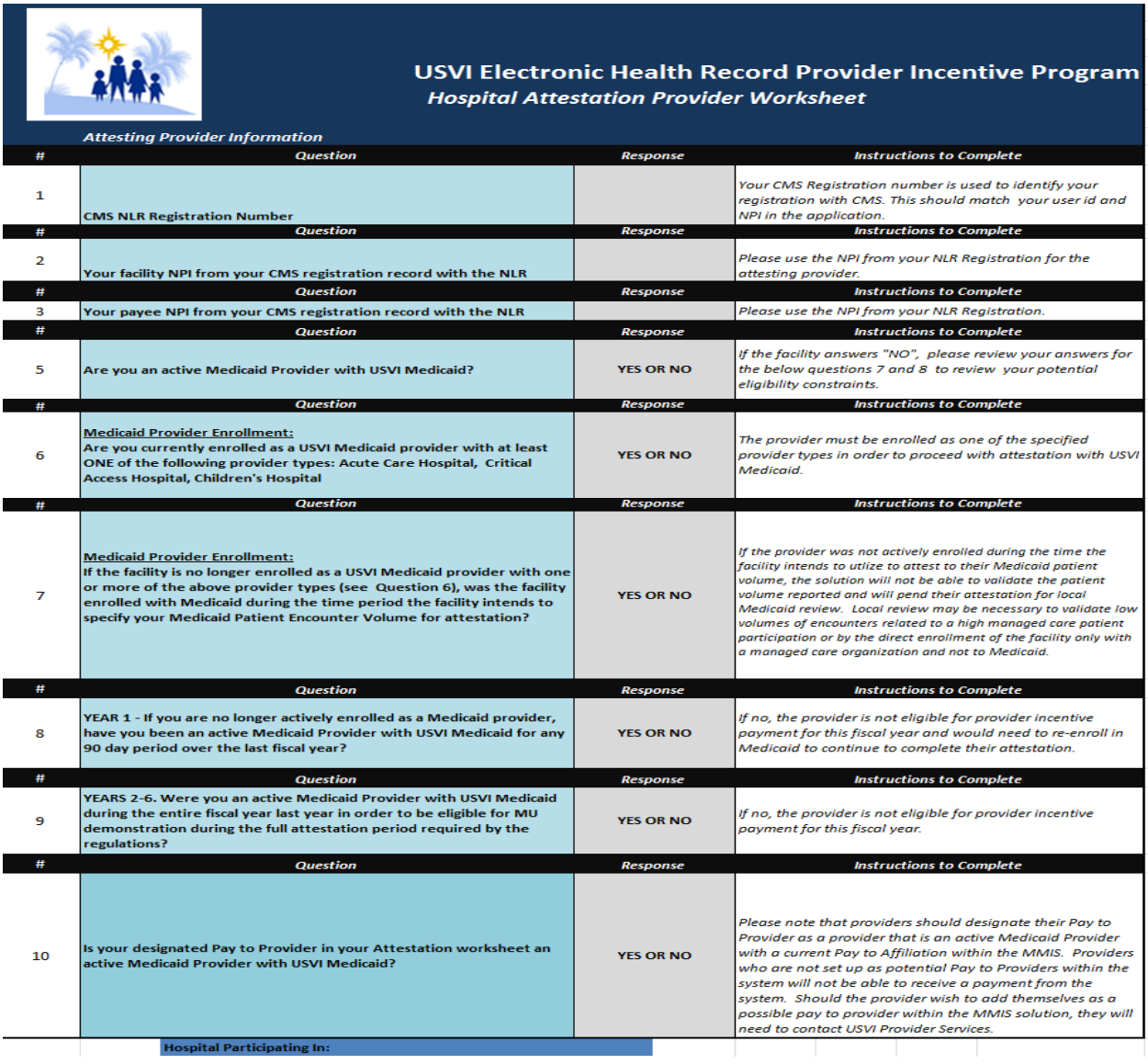
Additional items that you will need are listed here:
- USVI HealthPas User ID and Password
- Registration ID receive from CMS after registering
- CMS Certification Number for your EHR/EMR system. Access http://onc-chpl.force.com/ehrcert website to find the number
- Have a reliable internet connection
- Web brower-- Microsoft Internet Explorer version 8 or higher is recommended

It is highly recommended all documentation used is retained in case of audit.

Figure 1 - Eligible Hospital Workbook Instructions

2.2 *Eligible Hospital Attestation Workbook – Provider Information*

The second tab of the workbook request from the hospital provider the identification requirements, provider type/specialty requirements and enrollment requirements for the USVI Medicaid EHR Incentive payment attestation. The figure below shows an example of this worksheet page and displays the questions and details for the hospital provider's representative to utilize.



USVI Electronic Health Record Provider Incentive Program
Hospital Attestation Provider Worksheet

Attesting Provider Information

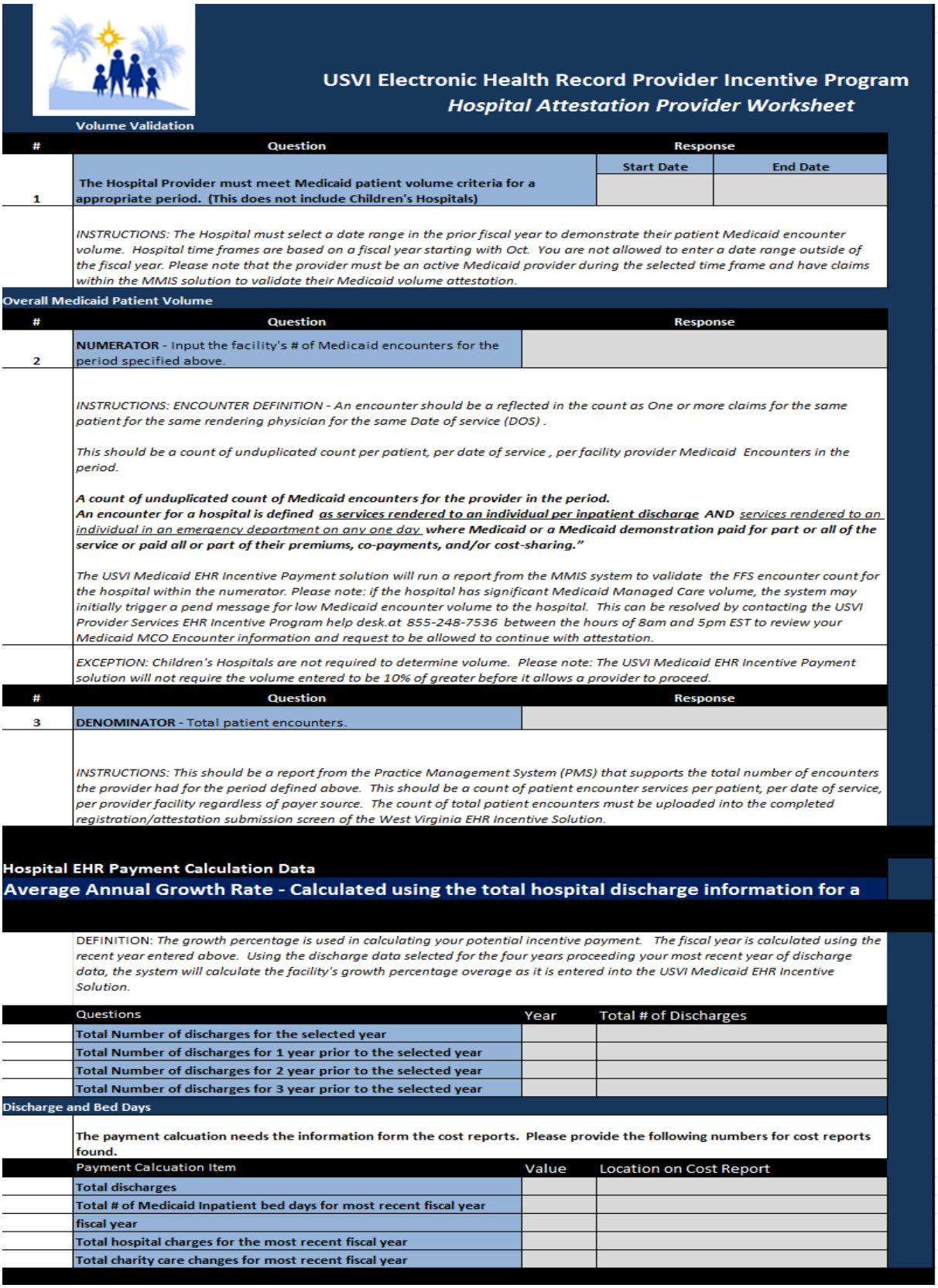
#	Question	Response	Instructions to Complete
1	CMS NLR Registration Number		*Your CMS Registration number is used to identify your registration with CMS. This should match your user id and NPI in the application.*
#	Question	Response	Instructions to Complete
2	Your facility NPI from your CMS registration record with the NLR		*Please use the NPI from your NLR Registration for the attesting provider.*
#	Question	Response	Instructions to Complete
3	Your payee NPI from your CMS registration record with the NLR		*Please use the NPI from your NLR Registration.*
#	Question	Response	Instructions to Complete
5	Are you an active Medicaid Provider with USVI Medicaid?	YES OR NO	*If the facility answers "NO", please review your answers for the below questions 7 and 8 to review your potential eligibility constraints.*
#	Question	Response	Instructions to Complete
6	Medicaid Provider Enrollment: Are you currently enrolled as a USVI Medicaid provider with at least ONE of the following provider types: Acute Care Hospital, Critical Access Hospital, Children's Hospital	YES OR NO	*The provider must be enrolled as one of the specified provider types in order to proceed with attestation with USVI Medicaid.*
#	Question	Response	Instructions to Complete
7	Medicaid Provider Enrollment: If the facility is no longer enrolled as a USVI Medicaid provider with one or more of the above provider types (see Question 6), was the facility enrolled with Medicaid during the time period the facility intends to specify your Medicaid Patient Encounter Volume for attestation?	YES OR NO	*If the provider was not actively enrolled during the time the facility intends to utilize to attest to their Medicaid patient volume, the solution will not be able to validate the patient volume reported and will pend their attestation for local Medicaid review. Local review may be necessary to validate low volumes of encounters related to a high managed care patient participation or by the direct enrollment of the facility only with a managed care organization and not to Medicaid.*
#	Question	Response	Instructions to Complete
8	YEAR 1 - If you are no longer actively enrolled as a Medicaid provider, have you been an active Medicaid Provider with USVI Medicaid for any 90 day period over the last fiscal year?	YES OR NO	*If no, the provider is not eligible for provider incentive payment for this fiscal year and would need to re-enroll in Medicaid to continue to complete their attestation.*
#	Question	Response	Instructions to Complete
9	YEARS 2-6. Were you an active Medicaid Provider with USVI Medicaid during the entire fiscal year last year in order to be eligible for MU demonstration during the full attestation period required by the regulations?	YES OR NO	*If no, the provider is not eligible for provider incentive payment for this fiscal year.*
#	Question	Response	Instructions to Complete
10	Is your designated Pay to Provider in your Attestation worksheet an active Medicaid Provider with USVI Medicaid?	YES OR NO	*Please note that providers should designate their Pay to Provider as a provider that is an active Medicaid Provider with a current Pay to Affiliation within the MMIS. Providers who are not set up as potential Pay to Providers within the system will not be able to receive a payment from the system. Should the provider wish to add themselves as a possible pay to provider within the MMIS solution, they will need to contact USVI Provider Services.*

Hospital Participating In:

Figure 2 - Eligible Hospital Workbook Eligibility

2.3 Eligible Hospital Attestation Workbook – Medicaid Volume Information

The third tab of the workbook requests from the hospital provider the Medicaid Volume requirements for the USVI Medicaid EHR Incentive payment attestation. The figure below displays the questions and details on this tab for the hospital provider's representative to utilize.



USVI Electronic Health Record Provider Incentive Program

Hospital Attestation Provider Worksheet

Volume Validation

#	Question	Response	
		Start Date	End Date
1	The Hospital Provider must meet Medicaid patient volume criteria for a appropriate period. (This does not include Children's Hospitals)		

INSTRUCTIONS: The Hospital must select a date range in the prior fiscal year to demonstrate their patient Medicaid encounter volume. Hospital time frames are based on a fiscal year starting with Oct. You are not allowed to enter a date range outside of the fiscal year. Please note that the provider must be an active Medicaid provider during the selected time frame and have claims within the MMIS solution to validate their Medicaid volume attestation.

Overall Medicaid Patient Volume

#	Question	Response
2	**NUMERATOR** - Input the facility's # of Medicaid encounters for the period specified above.	

INSTRUCTIONS: ENCOUNTER DEFINITION - An encounter should be a reflected in the count as One or more claims for the same patient for the same rendering physician for the same Date of service (DOS) .

This should be a count of unduplicated count per patient, per date of service , per facility provider Medicaid Encounters in the period.

A count of unduplicated count of Medicaid encounters for the provider in the period.
An encounter for a hospital is defined as services rendered to an individual per inpatient discharge AND services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration paid for part or all of the service or paid all or part of their premiums, co-payments, and/or cost-sharing."

The USVI Medicaid EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS encounter count for the hospital within the numerator. Please note: if the hospital has significant Medicaid Managed Care volume, the system may initially trigger a pend message for low Medicaid encounter volume to the hospital. This can be resolved by contacting the USVI Provider Services EHR Incentive Program help desk.at 855-248-7536 between the hours of 8am and 5pm EST to review your Medicaid MCO Encounter information and request to be allowed to continue with attestation.

EXCEPTION: Children's Hospitals are not required to determine volume. Please note: The USVI Medicaid EHR Incentive Payment solution will not require the volume entered to be 10% of greater before it allows a provider to proceed.

#	Question	Response
3	**DENOMINATOR** - Total patient encounters.	

INSTRUCTIONS: This should be a report from the Practice Management System (PMS) that supports the total number of encounters the provider had for the period defined above. This should be a count of patient encounter services per patient, per date of service, per provider facility regardless of payer source. The count of total patient encounters must be uploaded into the completed registration/attestation submission screen of the West Virginia EHR Incentive Solution.

Hospital EHR Payment Calculation Data

Average Annual Growth Rate - Calculated using the total hospital discharge information for a

DEFINITION: *The growth percentage is used in calculating your potential incentive payment. The fiscal year is calculated using the recent year entered above. Using the discharge data selected for the four years proceeding your most recent year of discharge data, the system will calculate the facility's growth percentage overage as it is entered into the USVI Medicaid EHR Incentive Solution.*

	Questions	Year	Total # of Discharges
	Total Number of discharges for the selected year		
	Total Number of discharges for 1 year prior to the selected year		
	Total Number of discharges for 2 year prior to the selected year		
	Total Number of discharges for 3 year prior to the selected year		

Discharge and Bed Days

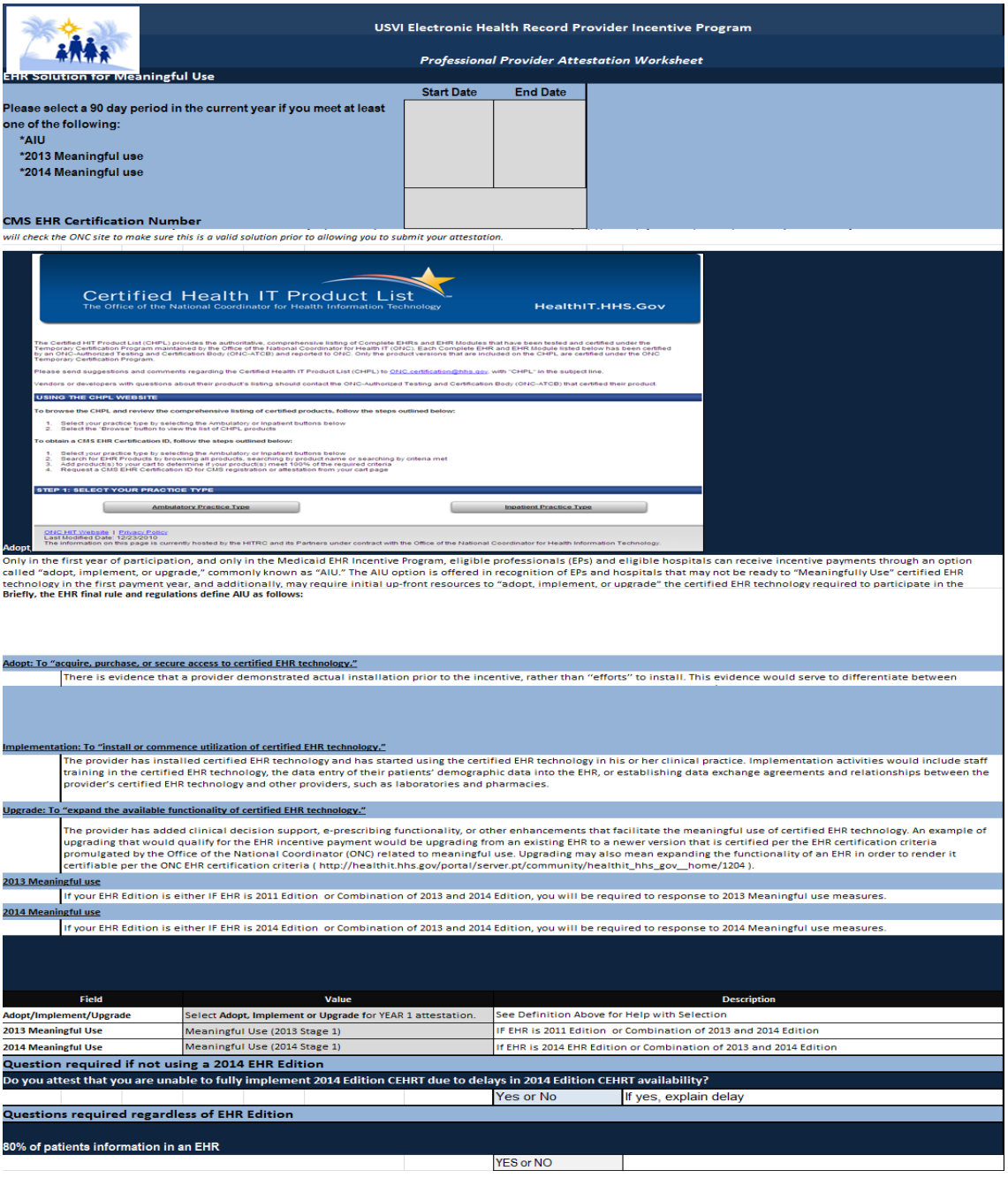
The payment calcuation needs the information form the cost reports. Please provide the following numbers for cost reports found.

	Payment Calcuation Item	Value	Location on Cost Report
	Total discharges		
	Total # of Medicaid Inpatient bed days for most recent fiscal year		
	fiscal year		
	Total hospital charges for the most recent fiscal year		
	Total charity care changes for most recent fiscal year		

Figure 3 - Eligible Hospital Workbook - Payment Calculation

2.4 Eligible Hospital Attestation Workbook –EHR Certification Information

The fourth tab of the workbook outlines the EHR Certification information requirements for the USVI Medicaid EHR Incentive payment attestation. This also informs the user where to find the EHR Certification number for the EHR system the facility is attesting to using, implementing, upgrading, or meaningful use. The figure below shows an example of this workbook page.



USVI Electronic Health Record Provider Incentive Program

Professional Provider Attestation Worksheet

EHR Solution for Meaningful Use

Please select a 90 day period in the current year if you meet at least one of the following: *AIU *2013 Meaningful use *2014 Meaningful use	Start Date	End Date

CMS EHR Certification Number

will check the ONC site to make sure this is a valid solution prior to allowing you to submit your attestation.

Certified Health IT Product List
The Office of the National Coordinator for Health Information Technology
HealthIT.HHS.Gov

The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed below has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.

Please send suggestions and comments regarding the Certified Health IT Product List (CHPL) to ONC.certification@hhs.gov, with "CHPL" in the subject line.

Vendors or developers with questions about their product's listing should contact the ONC-Authorized Testing and Certification Body (ONC-ATCB) that certified their product.

USING THE CHPL WEBSITE

To browse the CHPL and review the comprehensive listing of certified products, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Select the "Browse" button to view the list of CHPL products

To obtain a CMS EHR Certification ID, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Search for EHR Products by browsing all products, searching by product name or searching by criteria met
3. Add product(s) to your cart to determine if your product(s) meet 100% of the required criteria
4. Request a CMS EHR Certification ID for CMS registration or attestation from your cart page

STEP 1: SELECT YOUR PRACTICE TYPE

Ambulatory Practice Type | Inpatient Practice Type

ONC HIT Website | Privacy Policy
Last Modified Date: 12/23/2010
The information on this page is currently hosted by the HITRC and its Partners under contract with the Office of the National Coordinator for Health Information Technology.

Adopt

Only in the first year of participation, and only in the Medicaid EHR Incentive Program, eligible professionals (EPs) and eligible hospitals can receive incentive payments through an option called "adopt, implement, or upgrade," commonly known as "AIU." The AIU option is offered in recognition of EPs and hospitals that may not be ready to "Meaningfully Use" certified EHR technology in the first payment year, and additionally, may require initial up-front resources to "adopt, implement, or upgrade" the certified EHR technology required to participate in the

Briefly, the EHR final rule and regulations define AIU as follows:

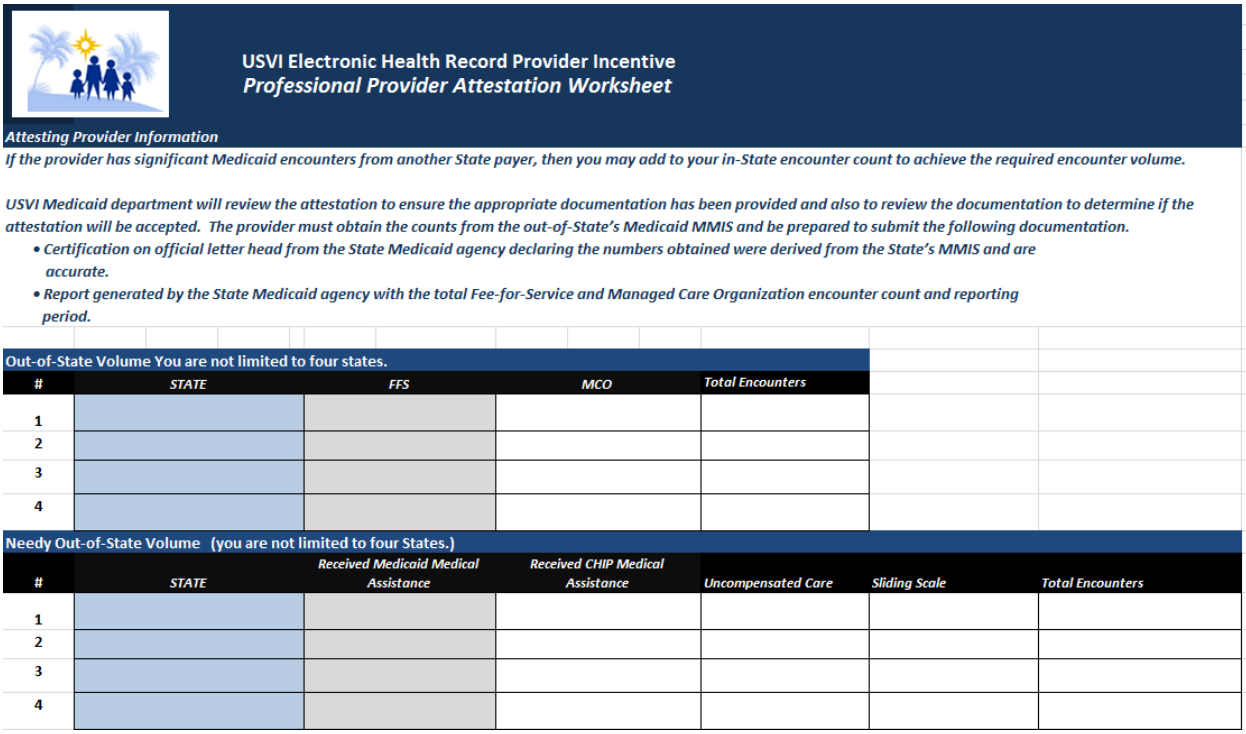
Adopt: To "acquire, purchase, or secure access to certified EHR technology."	
	There is evidence that a provider demonstrated actual installation prior to the incentive, rather than "efforts" to install. This evidence would serve to differentiate between
Implementation: To "install or commence utilization of certified EHR technology."	
	The provider has installed certified EHR technology and has started using the certified EHR technology in his or her clinical practice. Implementation activities would include staff training in the certified EHR technology, the data entry of their patients' demographic data into the EHR, or establishing data exchange agreements and relationships between the provider's certified EHR technology and other providers, such as laboratories and pharmacies.
Upgrade: To "expand the available functionality of certified EHR technology."	
	The provider has added clinical decision support, e-prescribing functionality, or other enhancements that facilitate the meaningful use of certified EHR technology. An example of upgrading that would qualify for the EHR incentive payment would be upgrading from an existing EHR to a newer version that is certified per the EHR certification criteria promulgated by the Office of the National Coordinator (ONC) related to meaningful use. Upgrading may also mean expanding the functionality of an EHR in order to render it certifiable per the ONC EHR certification criteria (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204).
2013 Meaningful use	
	If your EHR Edition is either IF EHR is 2011 Edition or Combination of 2013 and 2014 Edition, you will be required to response to 2013 Meaningful use measures.
2014 Meaningful use	
	If your EHR Edition is either IF EHR is 2014 Edition or Combination of 2013 and 2014 Edition, you will be required to response to 2014 Meaningful use measures.

Field	Value	Description
Adopt/Implement/Upgrade	Select **Adopt, Implement or Upgrade** for YEAR 1 attestation.	See Definition Above for Help with Selection
2013 Meaningful Use	Meaningful Use (2013 Stage 1)	IF EHR is 2011 Edition or Combination of 2013 and 2014 Edition
2014 Meaningful Use	Meaningful Use (2014 Stage 1)	If EHR is 2014 EHR Edition or Combination of 2013 and 2014 Edition
Question required if not using a 2014 EHR Edition		
Do you attest that you are unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability?		
	Yes or No	If yes, explain delay
Questions required regardless of EHR Edition		
80% of patients information in an EHR		
	YES or NO	

Figure 4 - Eligible Hospital Workbook - EHR Certification Information

2.5 *Eligible Hospital Attestation Workbook –Out-of-State Volume Entries*

The fifth tab of the worksheet captures the out-of-state volumes if needed.



USVI Electronic Health Record Provider Incentive
Professional Provider Attestation Worksheet

Attesting Provider Information

If the provider has significant Medicaid encounters from another State payer, then you may add to your in-State encounter count to achieve the required encounter volume.

USVI Medicaid department will review the attestation to ensure the appropriate documentation has been provided and also to review the documentation to determine if the attestation will be accepted. The provider must obtain the counts from the out-of-State's Medicaid MMIS and be prepared to submit the following documentation.

- *Certification on official letter head from the State Medicaid agency declaring the numbers obtained were derived from the State's MMIS and are accurate.*
- *Report generated by the State Medicaid agency with the total Fee-for-Service and Managed Care Organization encounter count and reporting period.*

Out-of-State Volume You are not limited to four states.

#	STATE	FFS	MCO	Total Encounters
1				
2				
3				
4				

Needy Out-of-State Volume (you are not limited to four States.)

#	STATE	Received Medicaid Medical Assistance	Received CHIP Medical Assistance	Uncompensated Care	Sliding Scale	Total Encounters
1						
2						
3						
4						

Figure 5 - Eligible Hospital Workbook - Out-of-State Entries

2.6 *Eligible Hospital Attestation Workbook –Meaningful Use Measures*

The remaining tabs in the workbook display the meaningful use Core Measures, the Menu Measures, and the Clinical Quality Measures for meaningful use 2013 Stage 1 and 2014 Stage 1.

3. Required Supporting Documentation

CMS and the DHS recommend documentation supporting hospital attestations are retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits.

The hospital must make all records and documentation available upon request to DHS, DHHS, or contracted entities acting on their behalf. Such records and documentation should include, but not be limited to, the following:

- ❑ Hospital Information (credentials)
- ❑ Identification of Service Sites
- ❑ Supporting material used to measure Medicaid patient volume (including Excel spreadsheets or any other report identifying discharge dates and emergency department information used to count patient encounters.)
- ❑ Invoices, lease agreements, contract or other documentation supporting adoption, implementation, or upgrading of ONC-certified EHR technology
- ❑ EHR reports supporting Meaningful Use meaningful use objectives and clinical quality measure information.

Please review DHS requirements and applicable provider manuals for the specific service requirements, retention periods, and lists.

Out of State Documentation

If the hospital plans to include encounter counts from another state (this is optional), the following documentation is required in an electronic format (pdf, Microsoft Word or Excel, or jpeg) and will need to be included with the electronic attestation:

- ❑ Certification on official letterhead from the other state Medicaid agency or agencies declaring the numbers obtained were derived from the State's MMIS and are accurate.
- ❑ Report generated by the other State Medicaid agency or agencies with the total Fee-for-Service and Managed Care Organization encounter count and reporting period.

4. Selecting Cost Reports

If your hospital is choosing to use its Medicare cost reports to complete its USVI Medicaid EHR Incentive Program overall payment calculation, it is imperative that the appropriate cost reports are selected. The Eligible Hospital Attestation Workbook provides the location of the Medicare cost report data elements that are needed to complete a payment calculation. Please be aware that 42 CFR 495.31 (g)(1)(i) (B) states that the discharge-related data amount must be calculated using a twelve month period that ends in the federal fiscal year before the hospital's fiscal year that serves as the first payment year.

To assist hospitals in determining the correct cost reporting period(s) to utilize in entering discharge and Medicaid share data used in calculating the facility's overall Medicaid EHR Incentive Program payment, the following reference is provided.

STEP 1: Enter the current federal fiscal year in which you are applying (If applying prior to 9/30/15 enter FY2014: if applying on or after 10/1/15 enter FY2015.)

STEP 2: Subtract from the date entered in Step 1, one fiscal year (Assuming FFY 2014 is entered, the date entered would be FFY 2013)

STEP 3: Select the year end cost report that falls within the FFY identified in Step 2

a. If Hospital A YE = 12/31; Hospital A must report discharge and Medicaid share data using the cost report ending 12/31/2012

b. If Hospital B YE = 6/30; Hospital B must report discharge and Medicaid share data using the cost report ending 6/30/2013

c. If Hospital C YE = 9/30; Hospital C must report discharge and Medicaid share data using the cost report ending 9/30/2013

5. Obtaining an USVI Medicaid Management Information System (VIMMIS) Login

USVI Medicaid providers must first have an account with the USVI Provider web portal **(www.vimmis.com**) in order to gain access to the USVI Medicaid Provider Incentive payment system.

To sign up for a login and password to the USVI Provider Web portal, a Medicaid enrolled provider must visit https://www.vimmis.com or contact USVI Medicaid Provider Services staff at 855-248-7536 option 2.

6. Enrolling in USVI Medicaid

Healthcare providers supporting USVI Medicaid patients must be active Medicaid enrolled providers for the timeframe that they will attest to the Medicaid patient volume and Electronic Health Record usage as it pertains to meeting the regulations.

If a practicing provider meets the appropriate provider type and Medicaid volume requirements and not actively enrolled as a USVI Medicaid provider at the time of attestation, then the provider must enroll with Medicaid to proceed with USVI Medicaid EHR Provider Incentive Payment application. Please contact the USVI Medicaid Provider Services Help Desk at 855-248-7536 option 3 between the hours of 8am and 5pm EST. Providers that enroll new to Medicaid will not be immediately eligible under the regulations and must wait the appropriate time to meet both the meaningful usage timeframes and Medicaid patient volume timeframes. Providers who have questions concerning current enrollment status, enrollment dates and enrolled type and specialty may also contact this number for assistance with enrollment.

7. Finding EHR Certification Number

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) is the body that tests and certifies electronic health record (EHR) systems. If the EHR system is approved, it is assigned a certification number. The website below is the Certified Health IT Product List website, http://onc-chpl.force.com/ehrcert, to look up your certified EHR technologies (CEHRT), add them to the cart, and then check out to obtain a EHR Certification Number for your CEHRT.

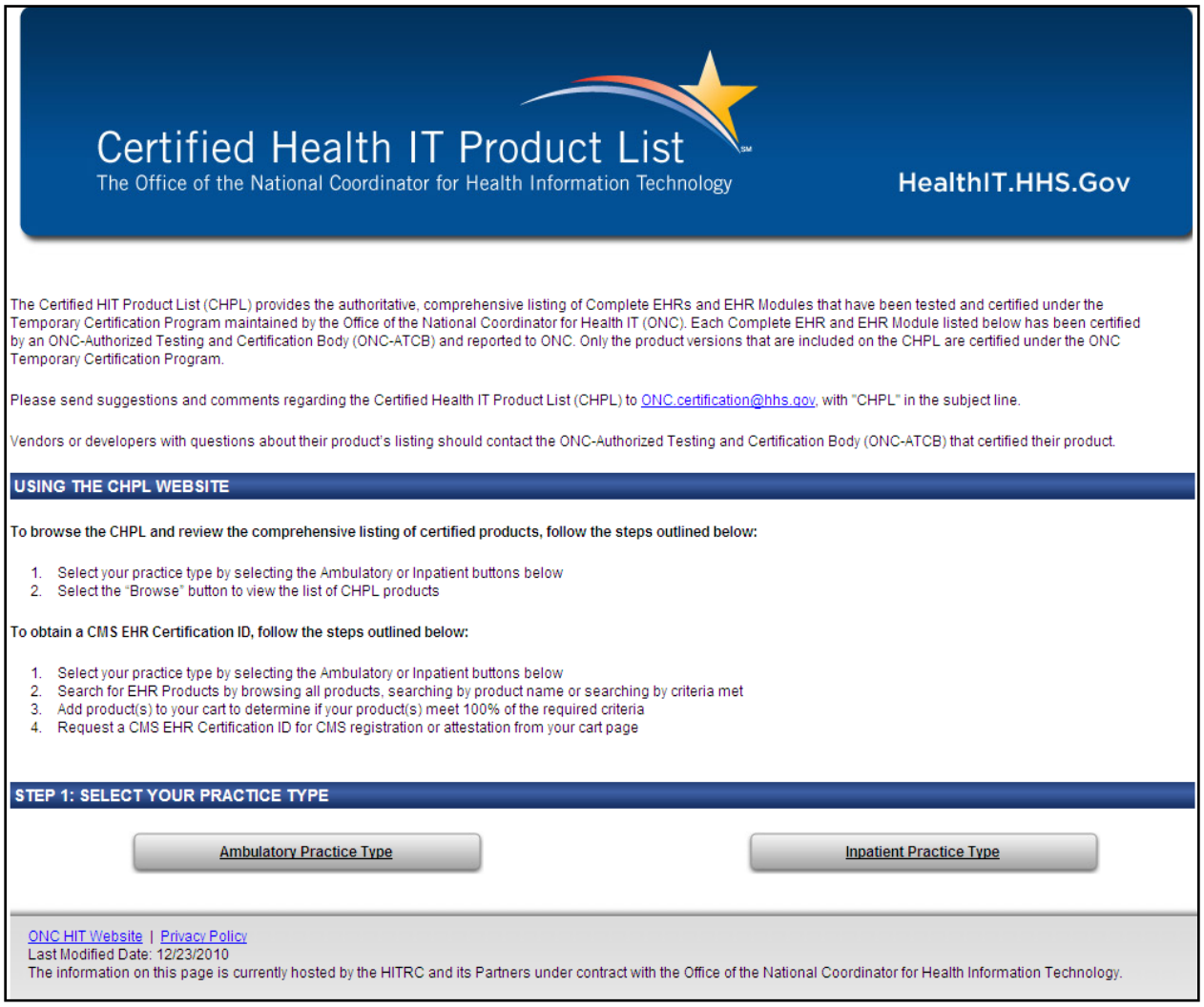


Figure 6 - CMS ONC Certification EHR Product Screen

8. System Requirements

To successfully use all features of the USVI Medicaid EHR Incentive Program Attestation application, ensure that the computer system meets the following minimum requirements:

- PC with a reliable internet connection.
- Web browser – The latest version of Microsoft Internet Explorer® (IE) is recommended or at least IE8. Earlier versions of IE may have display issues.
- Adobe Acrobat® Reader.

9. Navigation

This section describes the different navigation options within the navigation section that are not discussed throughout the user guide.

9.1 Breadcrumbs

When a hyperlink is clicked, the appropriate web page is displayed to the right of the navigation bar. The breadcrumbs indicate the current position within the site. Breadcrumbs are a visual representation of pages and sub-pages followed to reach this page. You may select the underlined name to return to the specific page. For the example screen, the breadcrumb translates to the following.

- The gray text that is not underlined in the breadcrumb indicates the section that you are currently in. In this case it is the Meaningful Core Measures questions.
- The underlined text will display the page that it is assigned. An example of the breadcrumb is as follows:
  - Attest displays the "Attestation Topics" Page.
  - Attestations displays the "Attestation Selection" Page.

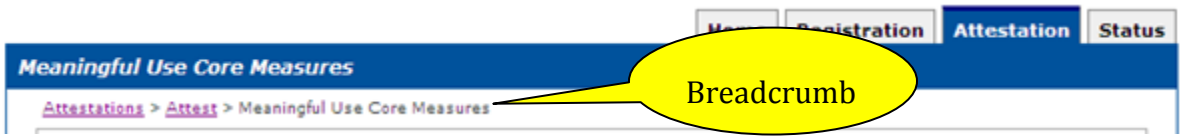


Figure 7 - Breadcrumb Example

9.2 Use of the Navigation Features

- Every screen of USVI Medicaid EHR Incentive Program Attestation application has a set of standard navigation features. These are found on the upper right had corner of the application screens as shown Figure 8 below.

Figure 8 - Navigation Features Example

9.2.1 Help Link

- Displays an electronic form of this document in a separate IE window.

9.2.2 USVI Medicaid EHR Incentive Program Attestation Application Account Hyperlink

Displays a screen with an email address box. USVI Medicaid EHR Incentive Program will use this email address to send notifications regarding the attestations. You may enter a new address, or update an existing one. Save changes by selecting the **"Update"** button. Press the **"Cancel"** button and changes will not be saved

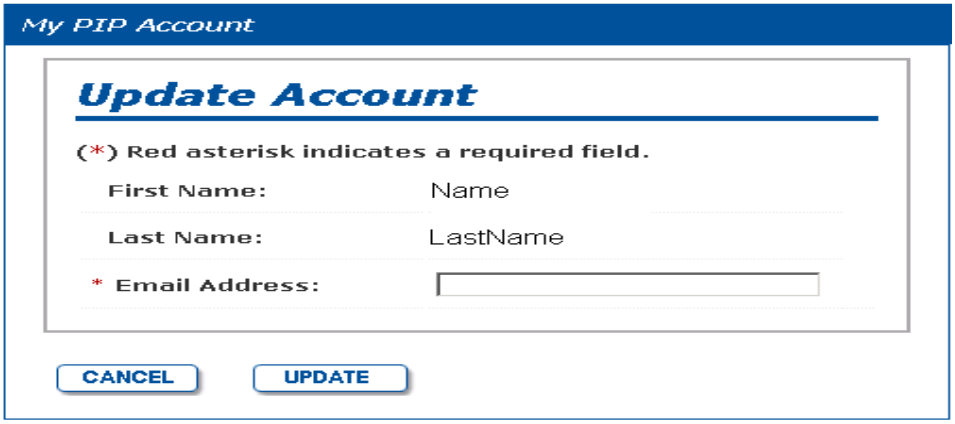


Figure 9 - Update Account Screen Example

9.2.3 Back to USVI MMIS Portal link

- Displays the USVI MMIS Portal "Login" page. Refer to Figure 15 - USVI Login Page.

9.2.4 Home Tab

- Displays the "Home" page as shown in Figure 10.

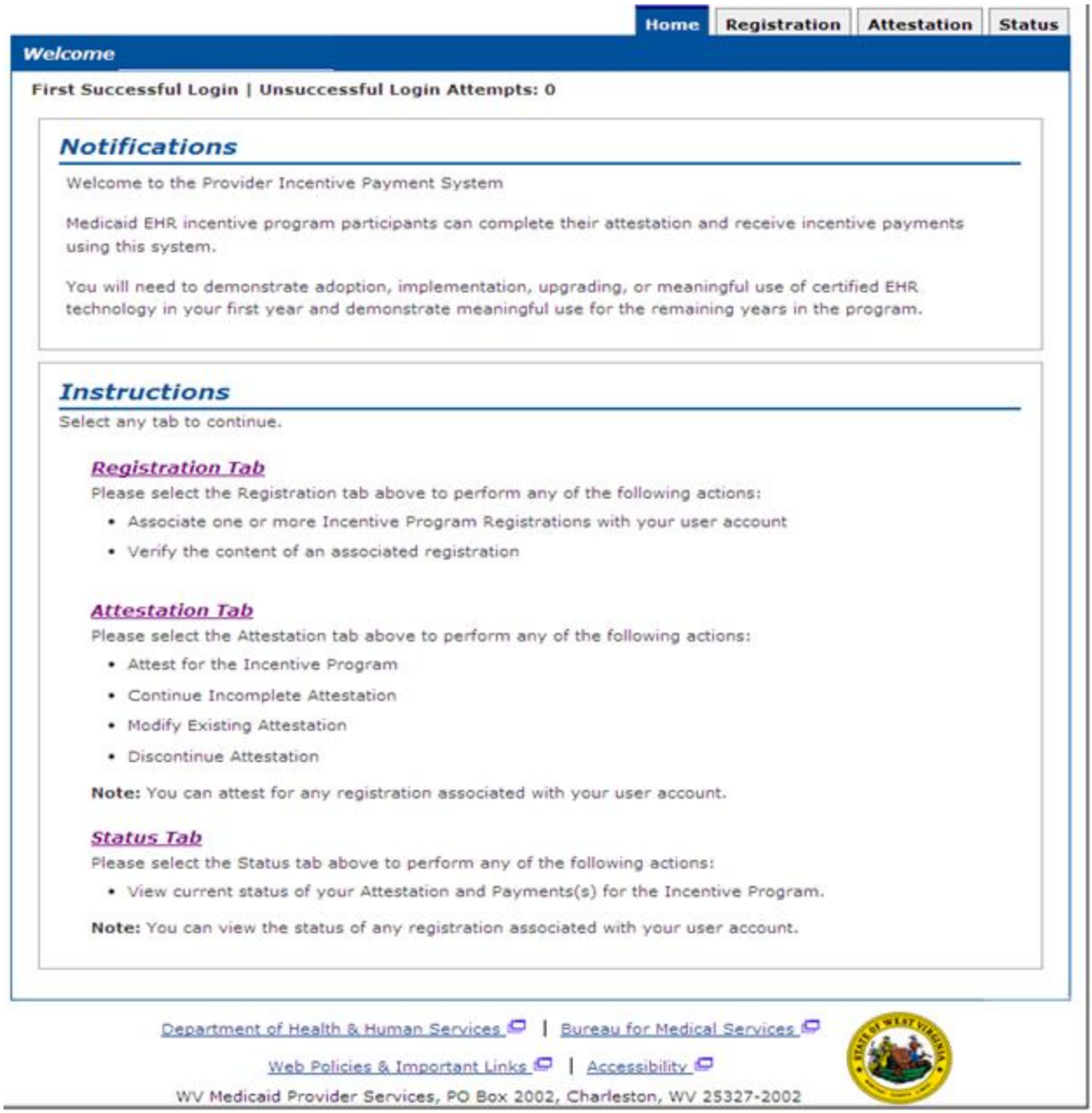


Figure 10 - Home Page Example

9.2.5 Registration Tab

The *Registration* tab displays the "Registration Instruction" page as shown in Figure 11 below.

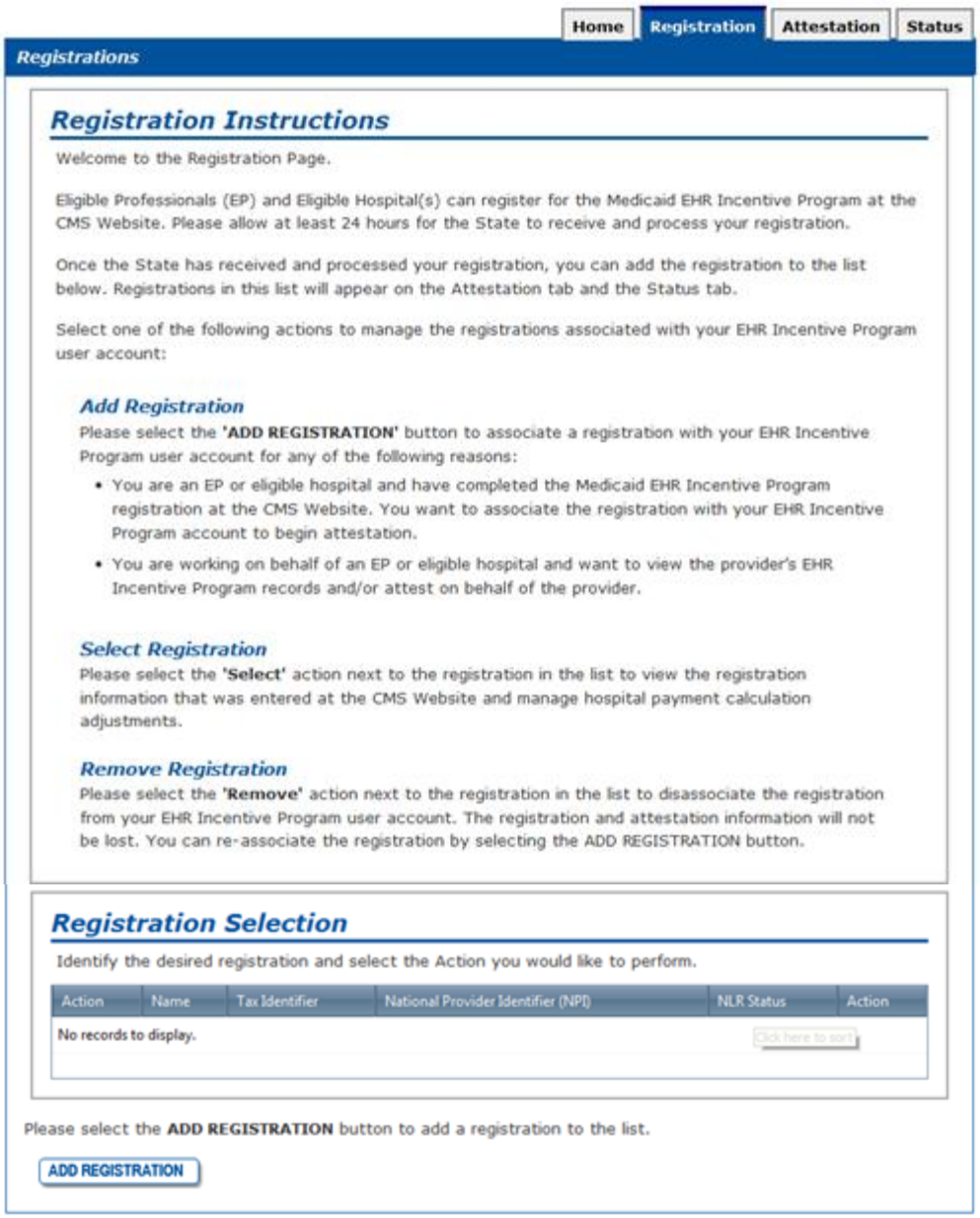


Figure 11 - Registration Instructions Page

9.2.6 Attestation Tab

The *Attestation* tab displays the "Attestation" home Page shown in Figure 12.

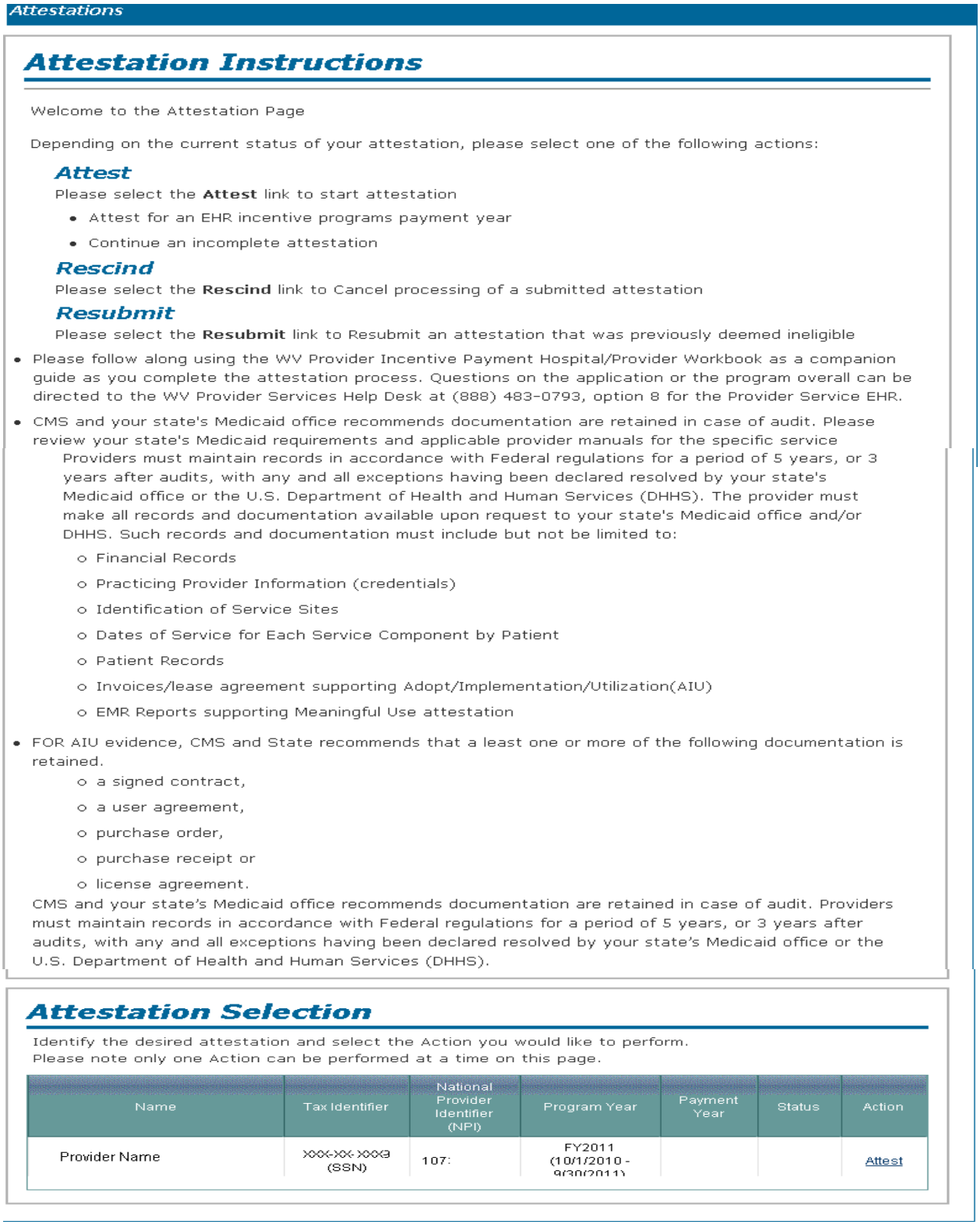


Figure 12 - Attestation Instructions Page

9.2.7 The Standard Buttons.

There are certain buttons found below the fields of each functional window that enables certain actions. The available actions depend on the purpose of the window. The most common buttons associated with USVI Medicaid EHR Incentive Payment Program are the **"Previous Page"** and the **"Save and Continue"** buttons. The **"Previous Page"** button displays the previous page in page sequence. The **"Save and Continue"** button must be selected. If not, any entries in the window are lost and must be reentered. The **"Submit"** button is also an option and is used when the user is ready to submit the answers for review and possible payment. Refer to Figure 13.

Figure 13 - Standard Buttons

10. Using the USVI Medicaid EHR Incentive Program Attestation Application

The USVI Medicaid EHR Incentive Program Attestation Application guides the user through the CMS required questions to determine if a provider is eligible to receive EHR Incentive Program payments. A workbook that contains the questions and the rules outlined by CMS is available and provides areas where answers may be recorded. A provider may enter the information or assign someone to enter the information on their behalf.

A provider may enter the information or assign someone to enter the information on their behalf.

The list below is the different sections. Each section will be discussed in detail.

- Pre-eligibility Checks which is done on the receipt of a registration id from CMS
- Login Instructions
- How to register a provider
- Entry of eligibility responses
    - Respond with Medicaid volume and determine if the amount is accurate. If not, then determine if certain criteria are met.
- Payment Schedule
- Entry of CMS EHR information
    - If meaningful use selected, entry of meaningful use objectives and clinical quality measures information is required
- Submit attestation

The figure below is a pictorial view of the USVI Medicaid EHR Incentive Program Attestation Application steps.

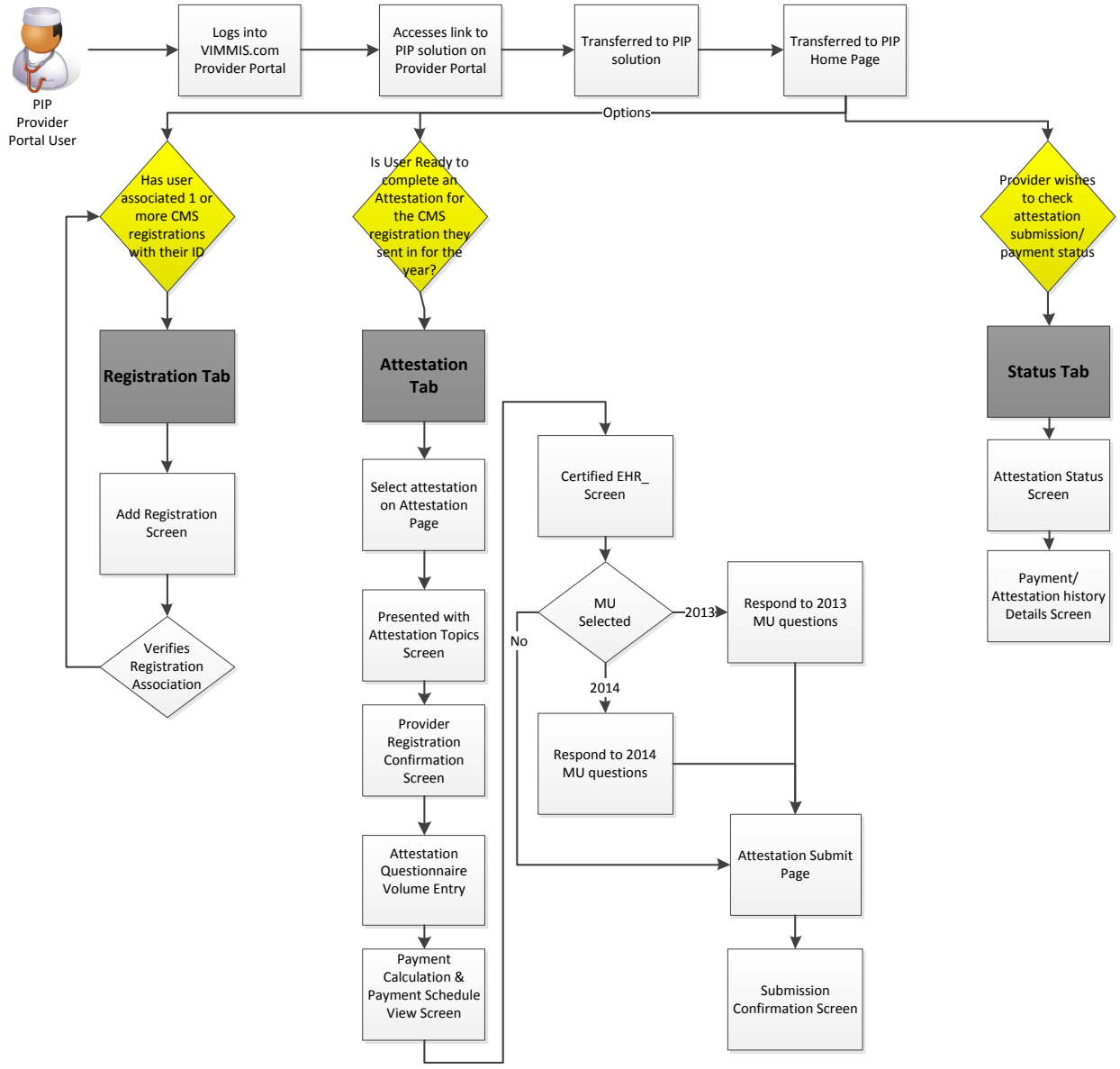


Figure 14 - Workflow Diagram

10.1 Pre-eligibility Check on Receipt of CMS Registration ID

When a registration is completed on the NLR site, the registration information is sent to the USVI Medicaid EHR Incentive Program application. The system will receive the registration and execute the following checks. The end result is that the pre-eligibility checks will determine if the provider is eligible or not.

The system will access the provider's Medicaid Enrollment records that are stored within the databases to determine if the provider is actively enrolled in the Medicaid program.

- **Enrollment Check**
  - The solution will check if the provider was actively enrolled in Medicaid for the attestation period. The attestation period is 90 days for AIU, 90 days for the first year of MU, and the entire calendar for all other MU years.

- **Provider Type Specialty Check**
  - The solution will check if the hospital's registration does not match its Medicaid enrollment with Acute Care, Critical Access Hospital (CAH), or Children's Hospital.

The hospital must meet the system's preliminary eligibility checks to be eligible to continue with attestation for Incentive Payment. If these checks are not met, the hospital is considered to be ineligible.

The USVI Medicaid EHR Incentive Payment Solution will send the CMS NLR an update file with the preliminary determined eligibility status of the provider for the Incentive Program under Medicaid. It will also send an email indicating the status of the USVI Provider's Medicaid registration eligibility check to the email address that was entered during registration. This email will indicate eligibility status from these eligibility checks. If the status shows the provider is ineligible, the email will contain the eligibility checks that were not met and information on contacting the USVI Provider Services Help Desk if the provider feels this is in error.

If the USVI Medicaid EHR Incentive Payment solution finds the provider ineligible, a user attempting to add the provider's registration to the user account to continue the application process for EHR Incentive payment will not be able to add the registration for the ineligible provider. The system prevents the provider from continuing with the attestation process unless the status is found to be eligible.

10.2 Login to the USVI Medicaid EHR Incentive Program Solution

This section provides instructions on how to start the USVI Medicaid EHR Incentive Program Attestation Application and log into the system to use the application. Please obtain authorization from the registering provider to enter the data on their behalf.

10.2.1 Starting USVI Medicaid EHR Incentive Program Attestation Application

The application runs on the Internet. Execute the following steps to start the application.

1. Access the web portal main page. As shown in the figure 15 below.

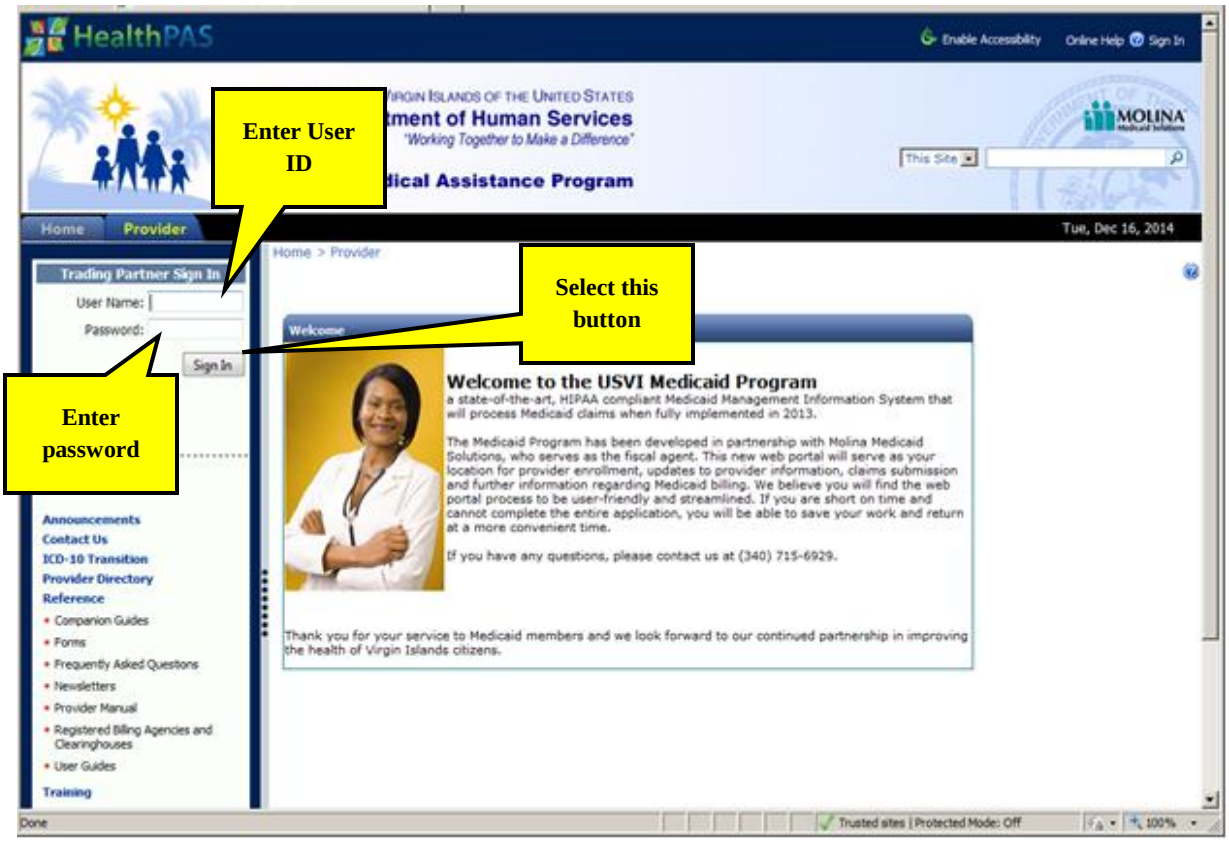


Figure 15 - USVI Provider Portal Login Screen Example

2. Prepare to Logon by entering in Logon Name and Password in the appropriate entry boxes and select **Submit**

   - ❑ Enter Provider Web portal user ID.
   - ❑ Enter Provider Web portal password.
   - ❑ Select **Submit** button

3. On the **Welcome** window, select the **USVI EHR Incentive Program** option to display the **Provider Incentive Program About This Site** page. Refer to **Figure 16** below.

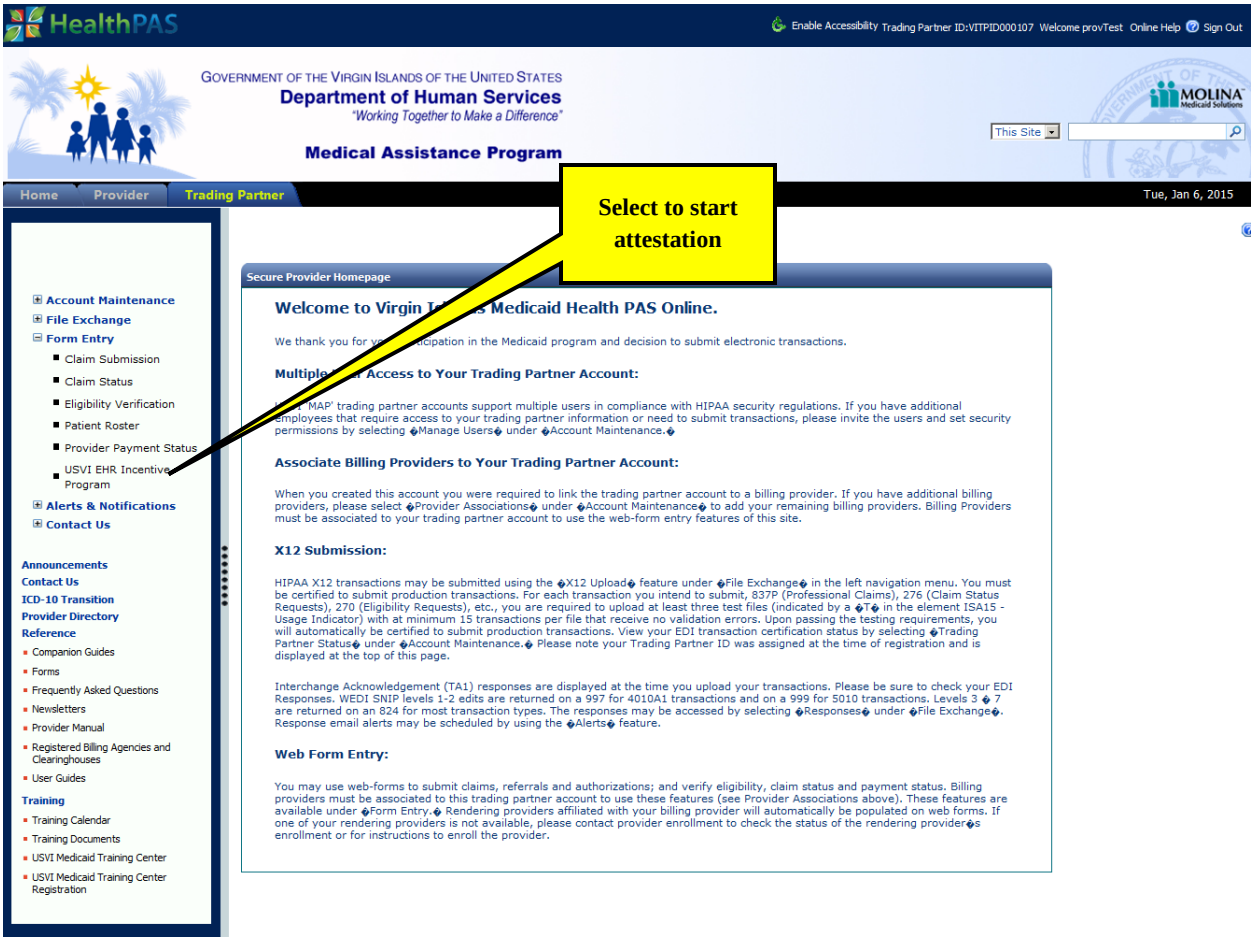


Figure 16 - USVI Provider Portal Welcome Page Example

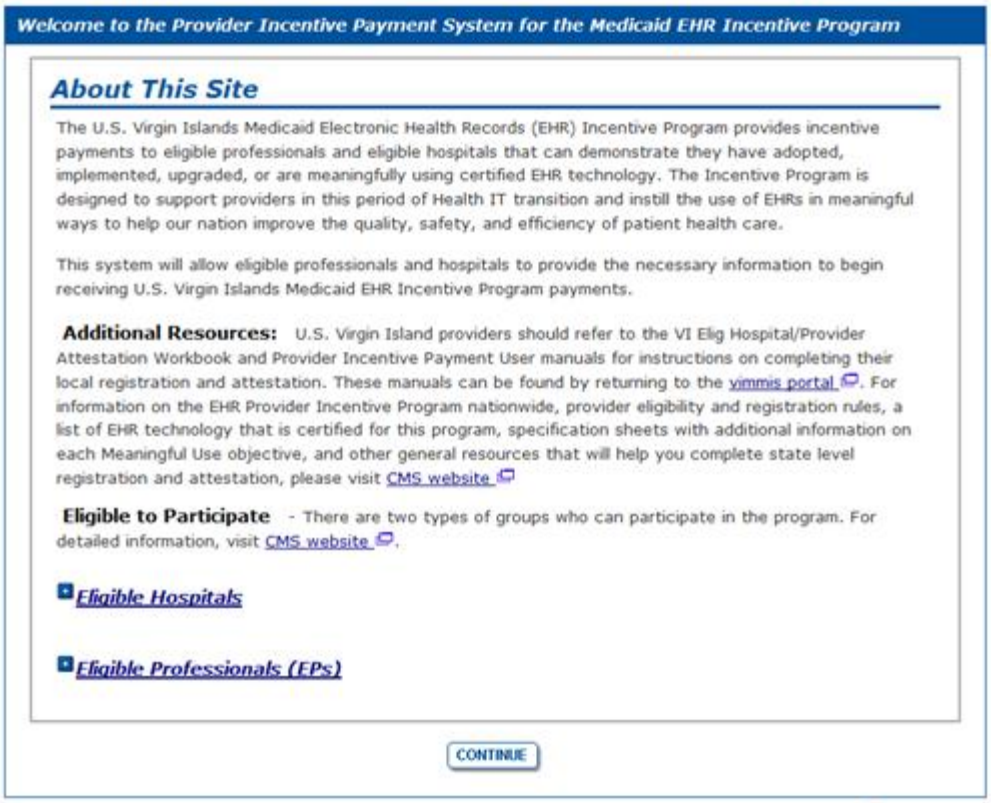


Figure 17 - Provider Incentive About This Site Example

4. On the **Provider Incentive About This Site** window, select the **Continue** button to display the **Provider Incentive Program Notifications** window (or also known as the Home page.) Refer to **Figure 18** below.

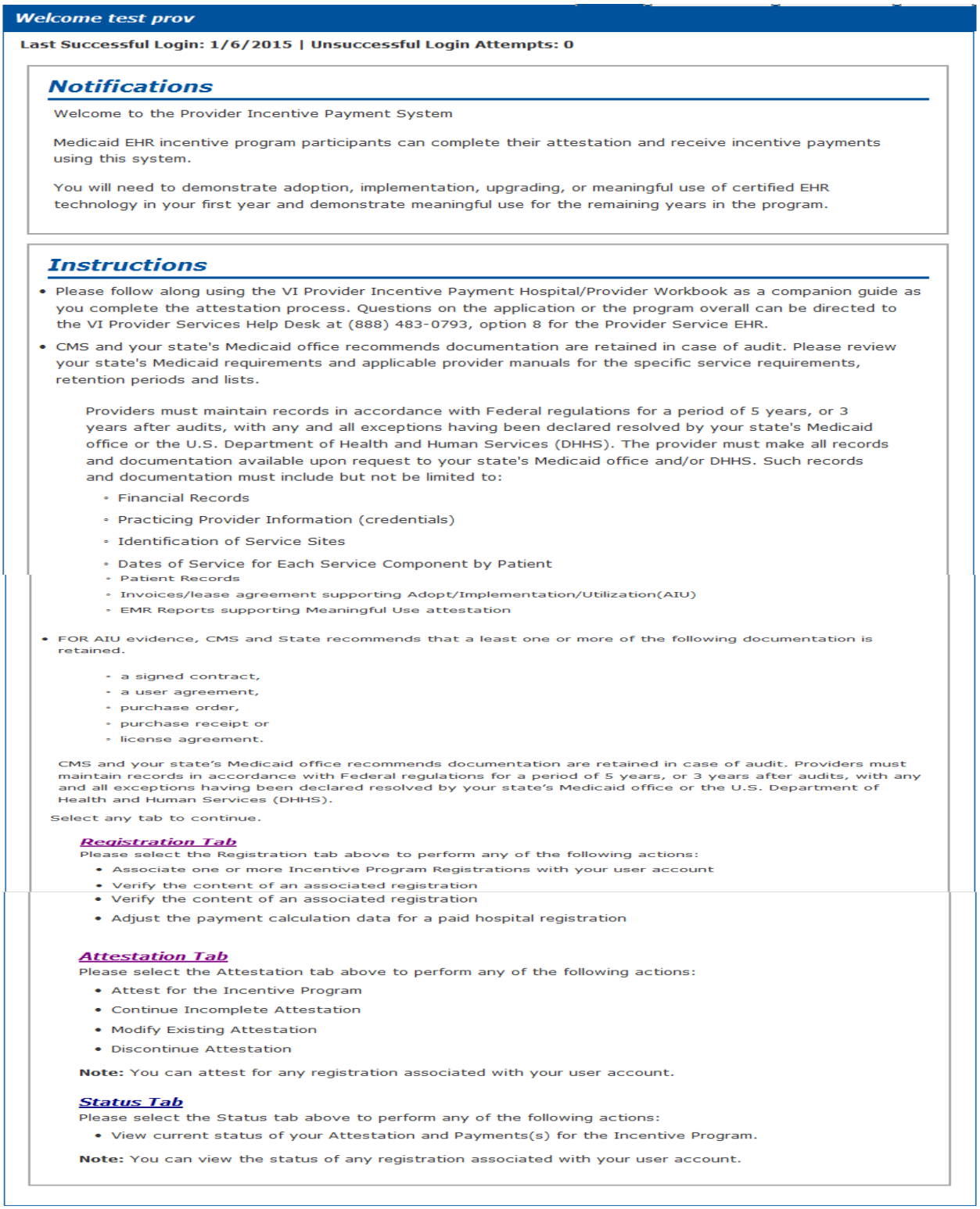


Figure 18 - Home Page Example

10.3 Registering a Provider within USVI Medicaid EHR Incentive Program

A registration number is a key component to the process. It is used along with the National Provider Identifier (NPI) to uniquely identify the provider. It is used within the CMS NLR environment to identify the provider and the provider incentive status. A registration ID is required in order to register and execute the attestation steps. A registration ID is obtained after using the CMS website to register the provider. The URL to CMS registration site is below. Please contact CMS if additional help is needed when using this URL.

- https://ehrincentives.cms.gov/hitech/login.action

After executing the CMS registration process, **please wait at least 48 hours** before executing this step. This allows CMS time to send the information to the USVI Medicaid EHR Incentive Program Attestation Application.

The Register tab allows the user to associate one or more provider registrations to the ID, view registration IDs that are attached to the user's ID, and remove any provider registrations. Please obtain authorization from the provider to enter the data on his behalf.

Registering the provider must be done before the user is allowed to attest. This step ensures that only the appropriate individual has access to the provider's information and can enter the data needed for attestation.

To view, add, and remove registrations, select the *Registration* tab on the navigation bar.

Figure 19 - Registration Tab Example

On selection, the "Registration Instruction" page displays. An example is **Figure 11** above.

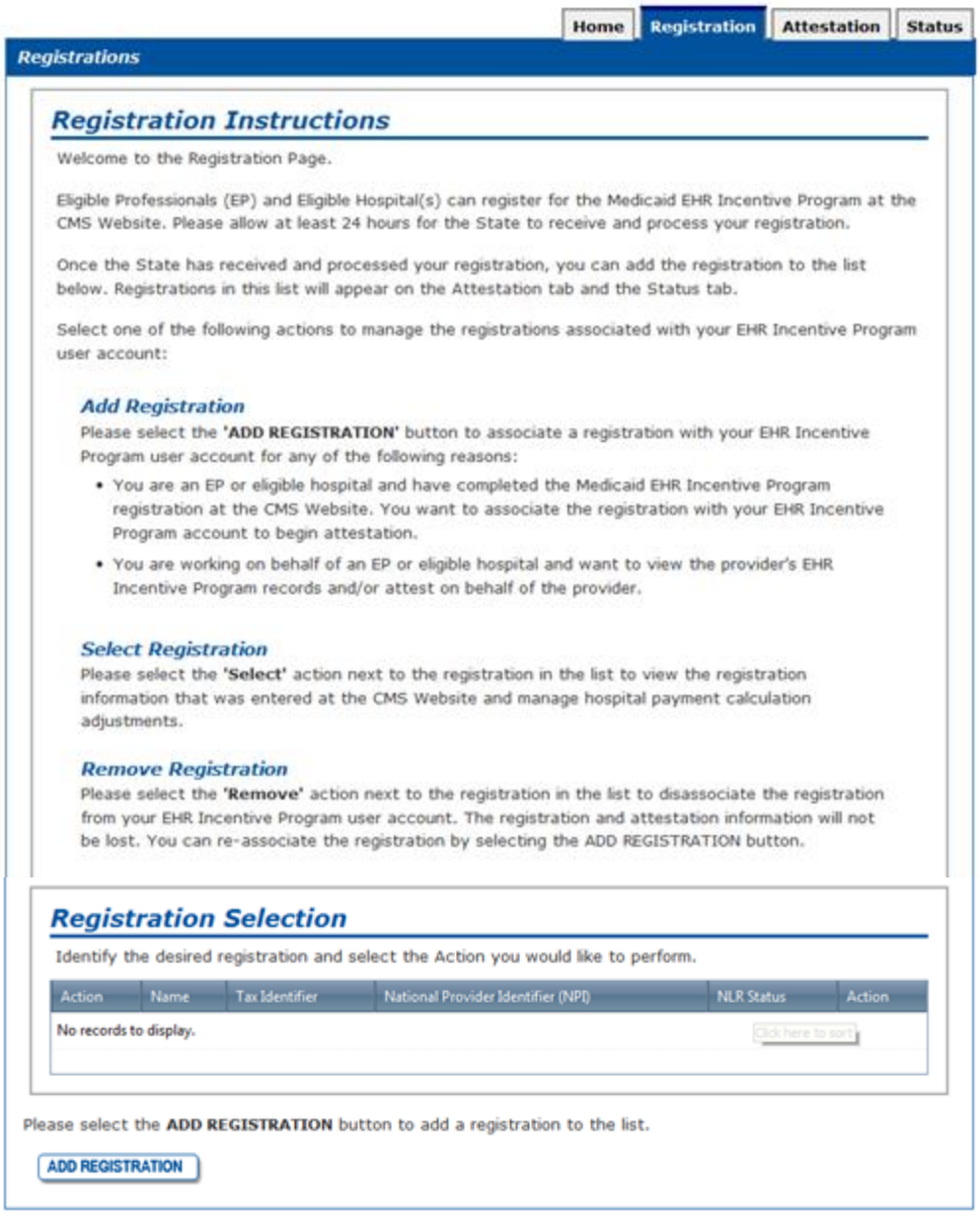


Figure 20 - Registration Select and Add Example

The "Registration Instructions" Home Page lists all registrations that you have added. If you have not added any, the Registration Selection section will display "No records to display" as shown in the figure below.

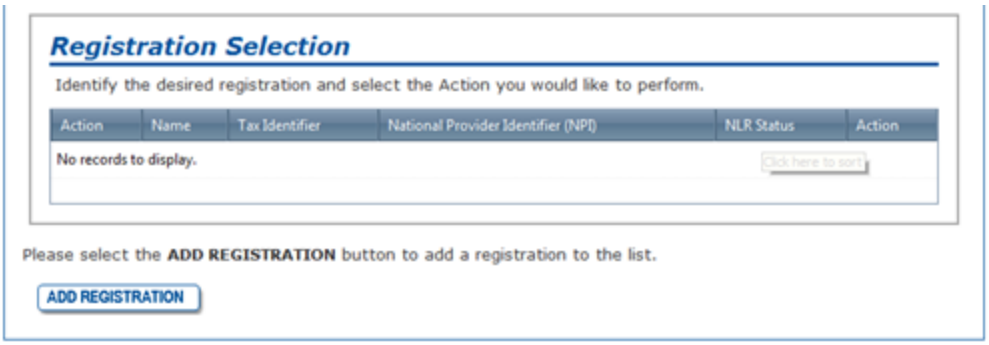


Figure 21 - Registration Selection No records to display example

The sections below explains the options that are available on the "Registration" Home Page, which are "Add Registration"," Select", and "Remove".

10.3.1 Registration – Add Option

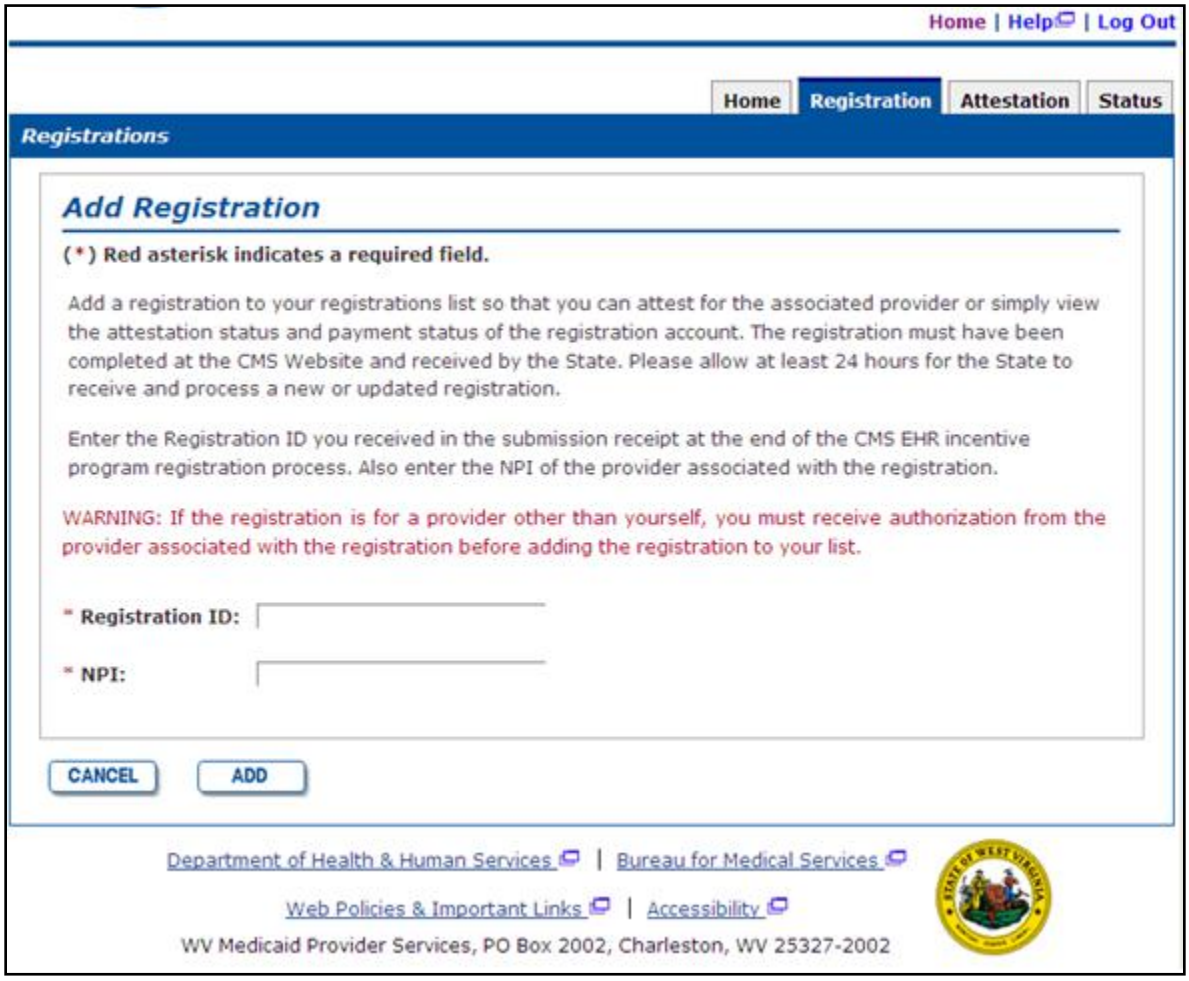


Figure 22 - Add Registration Example

1. Select the **Add Registration** button on the "Registration" Home Page.

2. Enter registration id obtained from the CMS web site.
3. Enter the NPI.
4. Select the **Add** button.

    - ❑ The system validates that the Registration ID is a valid id assigned by CMS and that the correct NPI was entered with it.

    - ❑ If valid, the registration ID and NPI is associated with the user ID. The "Registration Information" Page displays with the registration information that was entered. **Figure 23** is an example of the screen.

5. The **Previous Page** button returns to the "Registration" Home Page.

Figure 23 - Registration Information Example

If invalid, an error message displays. The "Add Registration" Page continues to display until the information is entered correctly or a navigation option is selected

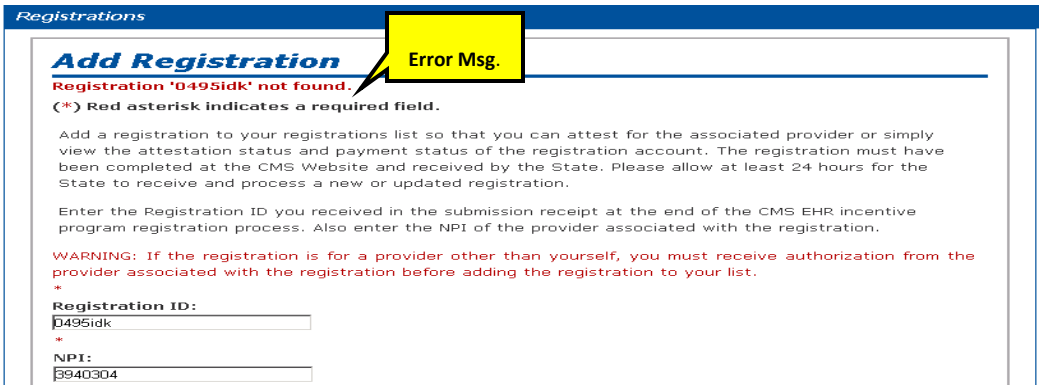


Figure 24 - Add Registration Error Message Example

The most common reasons why an error occurs:

- Information entered incorrectly. If necessary, access the CMS NLR website at ehrincentives.cms.gov to check the registration information or add a registration.
- The registration ID will not be found if 48 hours has not expired after registering with CMS.

The **Cancel** button is an additional option that is available. Selecting the **Cancel** button does not add the registration ID and the "Registration" Home Page displays. No additional registration ID displays.

10.3.2 Registration – Select Option

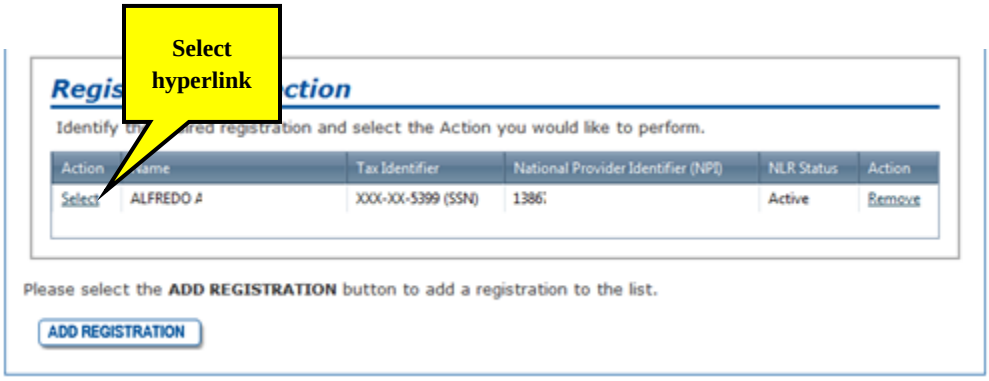


Figure 25 - Registration Select Example

When the **Select** link is selected, the registration details displays for the Registration ID selected. Refer to Figure 23.

10.3.3 Registration – Remove Option

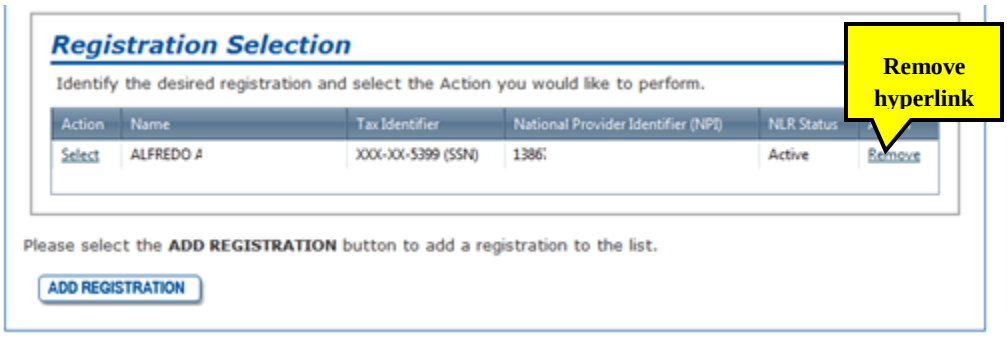


Figure 26 - Registration Remove Example

The **Remove** hyperlink next to a registration ID removes the registration ID from the user ID. The registration ID no longer displays in the registration and in the "Attestation" page. Refer to Figure 20.

The registration ID is still available for the user to reassign by executing the add registration steps described in section 10.3.1. The data that was entered is saved. NOTE: If someone else also registered the hospital, the data that was entered by this user will display.

.

10.4 Attestation

The provider selects a registration and continues with populating the hospital's attestation for that year. The solution will walk the provider through a series of screens with a questionnaire on Medicaid population and if applicable, meaningful use and clinical quality measure questions. The provider must complete these questions in order to proceed with submitting an attestation and potentially receiving payment.

The attestation workflow consists of the following topics. The application will guide the user through the topics. A topic does not become active until the prerequisite topic is completed. Each topic will be addressed.

- ❑ Verify Registration Information
  - ❑ Verify the provider information is the correct provider.
  - ❑ Ability to indicate proxy usage
- ❑ Eligibility Screens
  - ❑ These screens walk the provider through the attestation-specific eligibility questions that he must complete to be validated as an provider for the Incentive Program
    - ❑ These screens include:
      - ❑ Questions on hospital's practice location
      - ❑ Questions on hospital's Medicaid patient volume

- Payment Screens
  - These screens walk the provider through the expected payment schedule and questions related

- Certified EHR Technology Screen
  - Adopt, Implement, Upgrade, or Meaningfully Use Certified EHR Technology Screen
    - This screen validates that the EP is indeed using a valid EHR solution
    - If meaningful use selected, entry of meaningful use objectives and clinical quality measures information is required
- Submit Attestation

The Attestation process is accessible by selecting the *Attestation* Tab.

Figure 27 - Attestation Tab Example

When selected, the "Attestation Instructions" Page displays. This page displays the registration IDs that are assigned to the user.

The user does not need to complete the attestation process in one sitting. Each screen in the attestation workflow has a **Save and Continue** button. This will save changes and allow the user to stop at any time without the loss of data that was entered on that page. The attestation process does not allow the user to skip forward to screens or jump past a screen without entering data. The user may edit answers until the attestation has been submitted.

To start the attestation process

1. Select the **Attest** option on the row showing the hospital registration information.

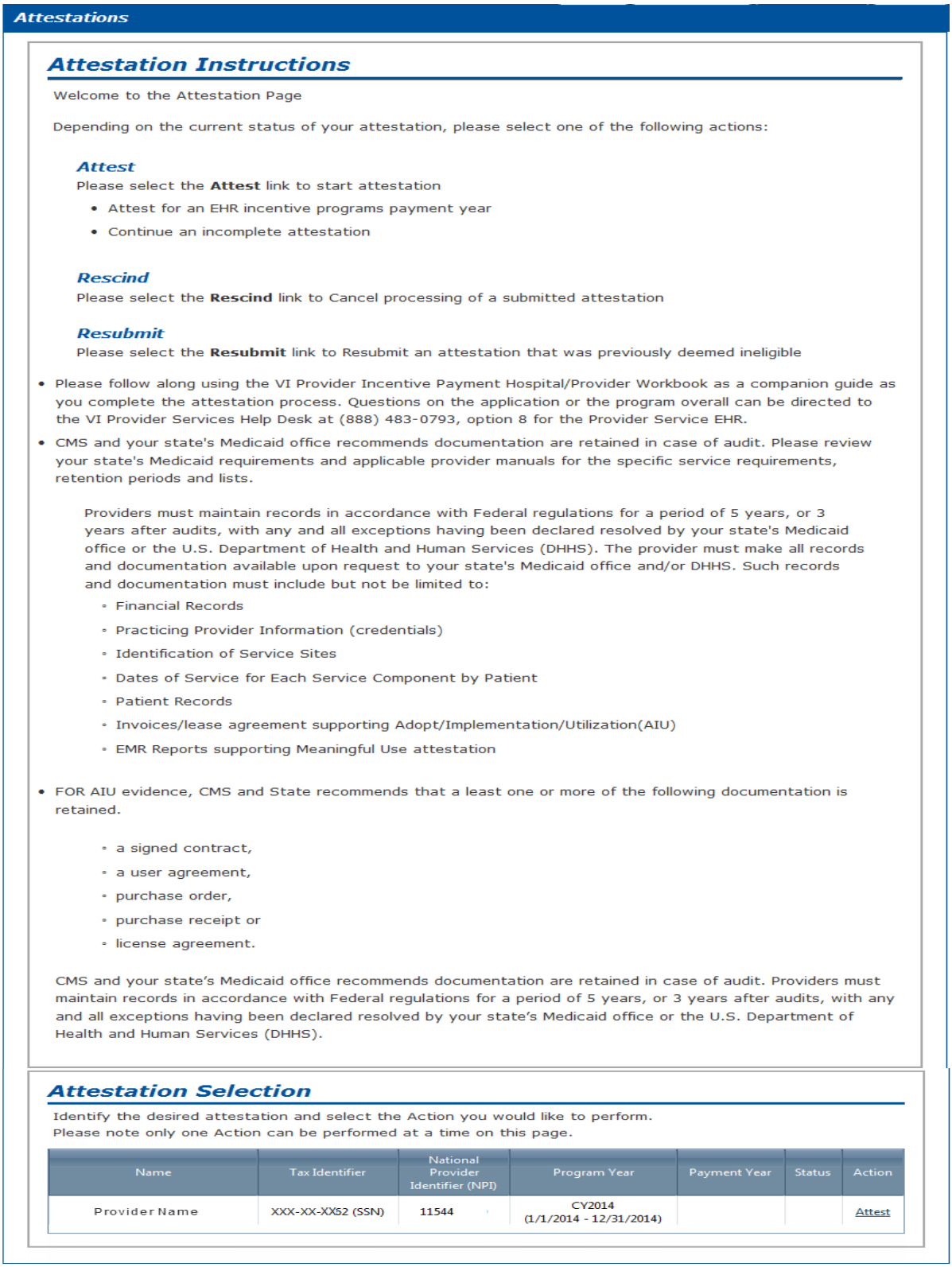


Figure 28 - Attestation Selection Example

1. Review the Attestation status displayed on the "Attestation Topics" Page. If the provider is not listed, please select the *Status* tab. The *Status* tab will display attestations that are not actionable. Locate the provider in the list to see the error that prevented the provider from executing the attestation process.
2. The topics available on this page are as follows:

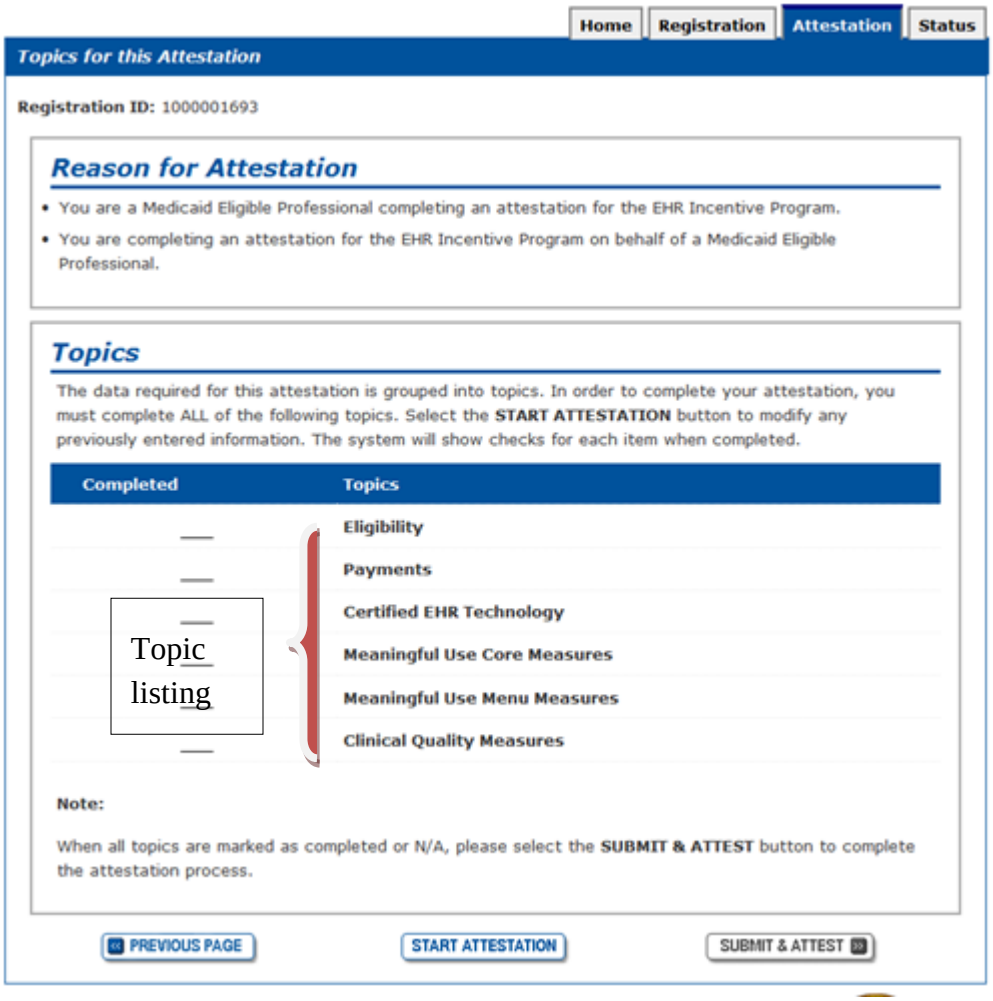


Figure 29 - Reason for Attestation Example

- The topic listing identifies the completed topic by placing an indicator next to the topic. A topic is completed when the required answers are entered and saved.
- Topics become available as prerequisite topics are completed.

Select the **Start Attestation** button to start the attestation process or to continue to add and modify data already entered.

Select the **Submit & Attest** button when satisfied with the data that is entered. This submits the responses to determine eligibility for payment processing. This submits the data to the State for review

- The **Submit & Attest** button is disabled on the initial selection of a registration id.
- The **Submit & Attest** button is disabled if the Eligibility check was set to "Ineligible".

Select the **Previous Page** button to display the "Attestation Instructions" Page.

On selection of the **Start Attestation** button, the "Registration Information" Page will display.

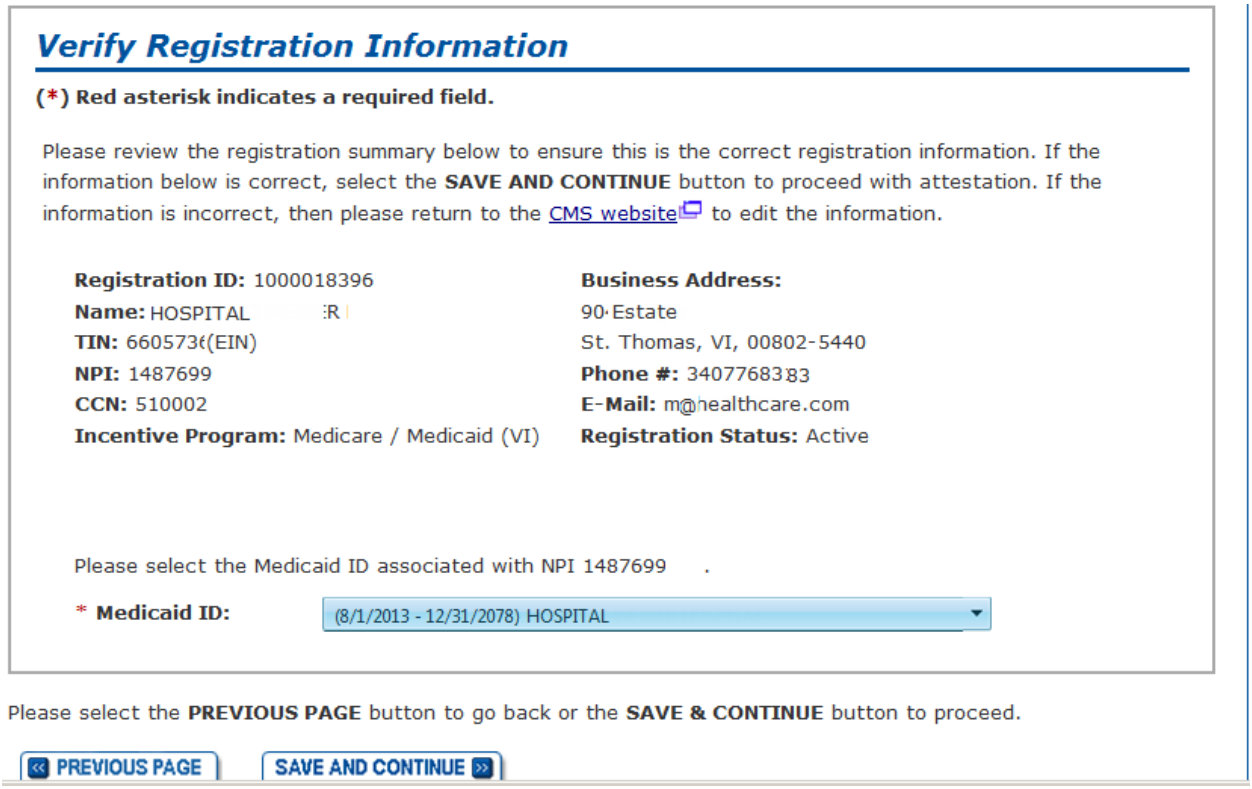


Figure 30 - Verify Registration Information Example

- Select the appropriate Medicaid ID using the dropdown box
  - Select the Medicaid ID to be associated with this attestation. A hospital can have one-to-many Medicaid IDs on file matching to the facility's single NPI. The designated NPI for institutional providers should match the Medicaid ID the facility wishes to have the payment sent to in order to ensure an appropriate match to the local Medicaid payee records.
- Select **Continue** button if after selecting the correct registration ID.

Select **Previous Page** if an incorrect registration ID was selected or if the user needs to return to the "Attestations Instructions" page or select the Attestation Tab

10.4.1 Attestation Eligibility

When the facility representative selects the organization's registration number and continues with the attestation portion of the USVI Medicaid EHR Incentive Program attestation process, the solution presents the user with a series of screens to complete the hospital's eligibility check and gather the appropriate data needed to calculate the hospital's overall USVI Medicaid EHR Incentive Program payment.

10.4.1.1 Eligibility Screen 1 – Volume Check

The purpose of this screen is to determine if the facility's Medicaid patient volume meets the threshold necessary to be eligible for a USVI Medicaid EHR Incentive payment.

In order to be eligible for the Medicaid EHR Incentive Program the hospital must have:

- CAH or Acute Care Hospitals must have at least 10% Medicaid volume
- Children's hospitals are exempt from volume check

USVI Medicaid EHR Incentive Program defines a hospital encounter as:

For purposes of calculating EP eligible patient volume, a Medicaid encounter as defined by the USVI Medicaid EHR Incentive Program is "An encounter should be a reflected in the count as one or more claims for the same patient for the same rendering physician for the same date of service (DOS). This should be a count of unduplicated per patient, per date of service Medicaid Claim Based Encounters in the 90 day period. This includes all Medicaid paid encounters including inpatient, outpatient, and emergency room services.

In other words, an eligible hospital should count the following as a patient encounter: One to many claims for the same patient where the claim has the same DOS and the same rendering/attending provider. All claims related to the actual "encounter" with the patient for the same date and same provider.

The USVI Medicaid EHR Incentive Program Attestation Application includes a calculation to derive the number of unduplicated encounters for a provider by reviewing all Medicaid paid and reversed claims for the provider within the VIMMIS for the selected 90 day patient volume period. The USVI Medicaid EHR Incentive Program Attestation Application will run a report from the MMIS to validate the fee-for-service claim and managed care encounter count entered.

If the hospital has significant Medicaid encounters from other state Medicaid agencies, then it may add to its in-state encounter count to meet the required encounter volume. The "Volume" page provides functionality to add and maintain out-of-state (OOS) volume counts. When an

attestation with OOS entries is submitted, the attestation will be placed in a Pend status, provided the in-state volume counts are validated. The USVI Medicaid EHR Incentive Program staff will review the attestation to ensure the appropriate documentation was provided and also to review the documentation to determine if the attestation will be accepted. The hospital must obtain the counts from the out-of-state Medicaid agency's MMIS and be prepared to submit the following documentation.

- Certification on official letterhead from the other state Medicaid agency declaring the numbers obtained were derived from the state's MMIS and are accurate.
- Report generated by the state Medicaid agency with the total fee-for-service count and reporting period.

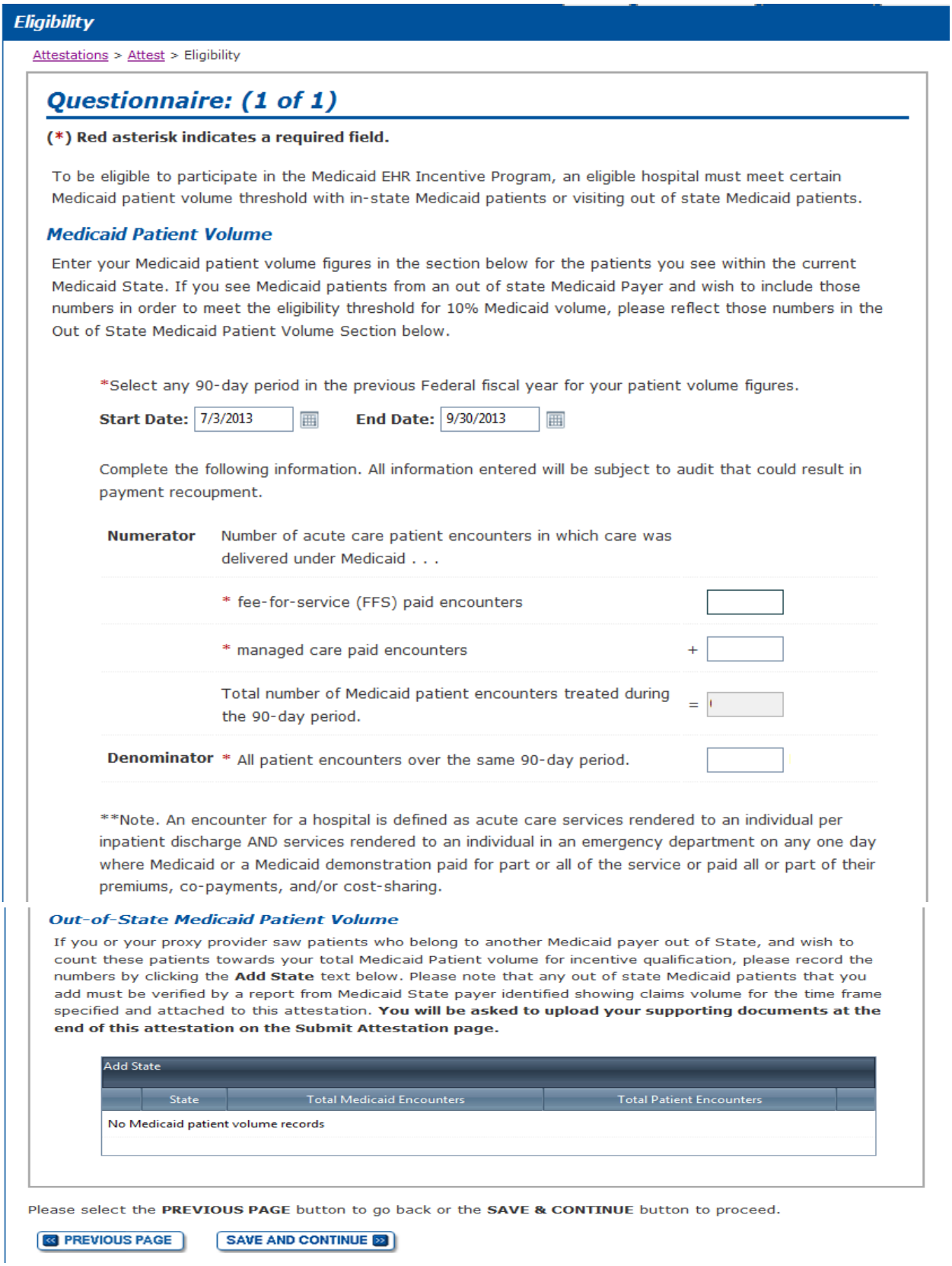


Figure 31 - Medicaid Volume Example

- NOTE: An encounter for hospitals is defined as the number of inpatient discharges and the number of emergency room encounters over a 90 day period in the federal fiscal year proceeding the attestation federal fiscal year. Enter start date by typing in the date or selecting the calendar icon. The system will automatically calculate the 90 day patient volume period end date.

1. Select the attestation period date range
2. Enter the numerator.
    - Enter in the Medicaid Fee-for-Service encounters
    - Enter in Medicaid Managed Care paid encounters
        - Do not add commas. System will format with commas after entry.
3. Enter the denominator.
        - Do not add commas. System will format with commas after entry.
4. Enter out-of-state counts (optional)

The screen allows for entry of out-of-state entries. The following is a sample of a screen to display the different options available to the user. Each option's instructions are bulleted sections following this screen shot.

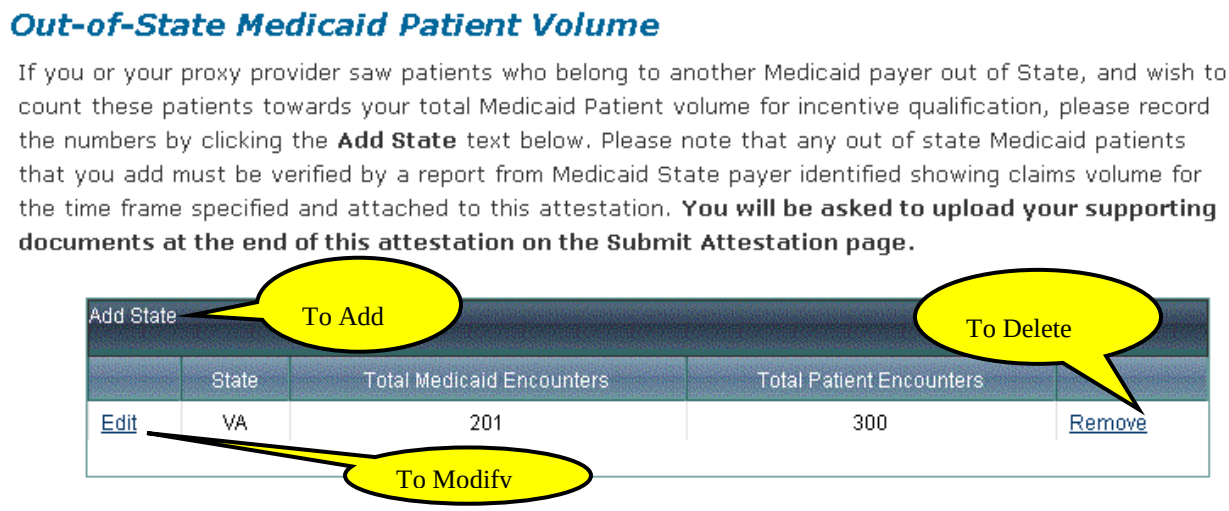


Figure 32 - Out-of-State Screen Example

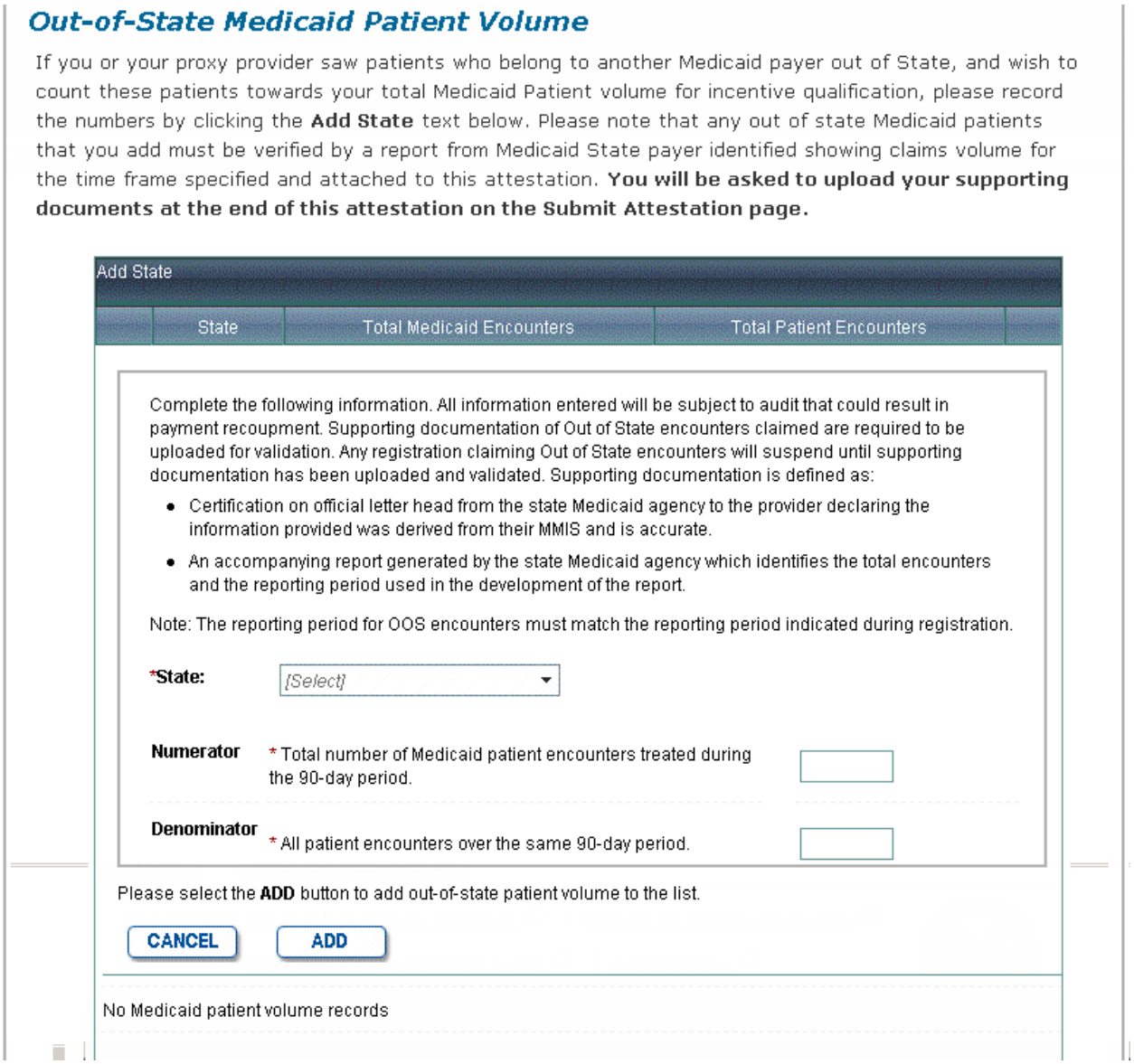


Figure 33 - Out-of-State Add Screen Example

- To add an out-of-state entry:
    1. Select "Add State" to display the screen above
    2. Select a state from the drop down list
    3. Enter numerator for the selected state
    4. Enter denominator, which is the total patient encounters for the state
    5. Select the **Add** button
    - ❑ To enter in patient volume information for additional states encounters, repeat Steps 1- 5.
- To modify out-of-state entry:

1. Select "Edit"
2. OOS screen displays with current entries, enter the correct patient encounters count
3. Select **Update** button

- To delete out-of-state entry:
    1. Select **Remove**
    2. Respond appropriately to the displayed question

Select **Save and Continue button** to save all entries and changes including any out-of-state entries.

The system validates if all fields have data entered.

- ❑ If any errors occur, check the dates, numerator, and denominator. Please enter the appropriate data.
- ❑ If no errors occur, the "Payment Calculation" Pages displays

10.4.2 Attestation Payment Amount

The payment amount is calculated during the eligible hospital's year 1 attestation. The Payment Schedule displays the amount that was calculated at that time.

- ❑ 50% in the first year
- ❑ 40% in the second year
- ❑ 10% in the third year

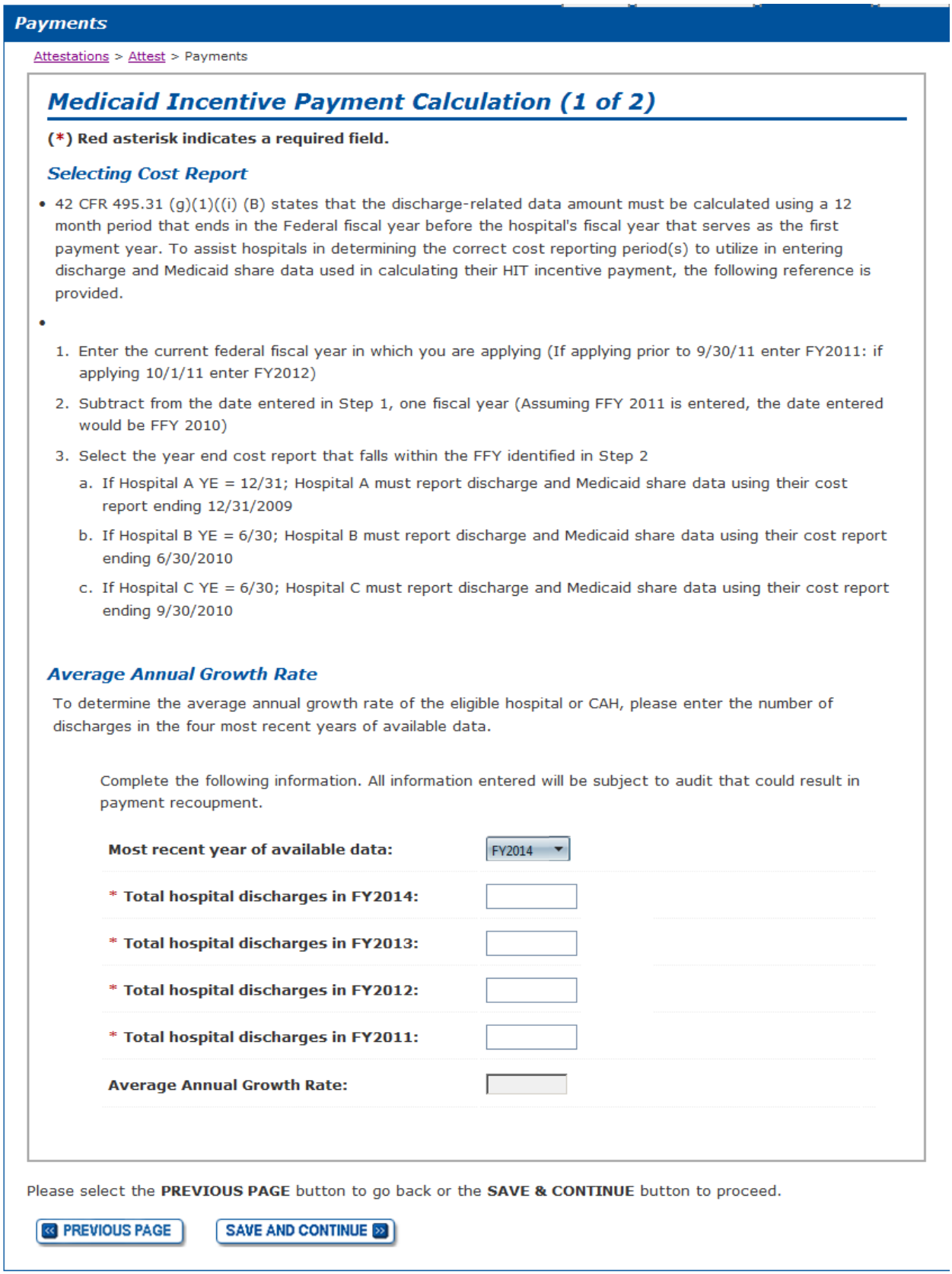


Figure 34 - Payment Calculation Question 1 Example

Please refer the following instructions to find the most recent year of available discharge data to determine your average annual growth percentage:

42 CFR 495.31 (g)(1)((i) (B) states that the discharge-related data amount must be calculated using a 12 month period that ends in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. To assist hospitals in determining the correct cost reporting period(s) to utilize in entering discharge and Medicaid share data used in calculating their USVI Medicaid EHR incentive payment, the following reference is provided.

1. Enter the current federal fiscal year in which you are applying (If applying prior to 9/30/11, enter FY2011: if applying 10/1/11, enter FY2012)

2. Subtract from the date entered in Step 1, one fiscal year (Assuming FFY 2011 is entered, the date entered would be FFY 2010)

Screen Entry Instructions

1. **Select the most recent year of available data from the dropdown field.**
2. **Enter total hospital discharges in FY20XX, where XX is the appropriate year.**
   - ❑ Do not add commas. System will format with commas after entry.
3. **Enter total hospital discharges in FY20XX, where XX is the appropriate year.**
   - ❑ Do not add commas. System will format with commas after entry.
4. **Enter total hospital discharges in FY20XX, where XX is the appropriate year.**
   - ❑ Do not add commas. System will format with commas after entry.
5. **Enter total hospital discharges in FY20XX, where XX is the appropriate year.**
   - ❑ Do not add commas. System will format with commas after entry.
6. **Step 6: System calculates the Average Annual Growth rate. It is not modifiable.**

   DEFINITION: The growth percentage is used in calculating potential incentive payment. The fiscal year is calculated using the recent year entered above. Using the discharge data selected for the four years preceding the most recent year of discharge data available via cost report, the system will calculate the facility's growth percentage average as it is entered into the USVI Medicaid EHR Incentive Payment solution.
7. **Step 7: Select Save and Continue.**

The system validates if all fields have data entered.

If errors occurs,

Supply numbers for each field. Please enter the appropriate data.

Execute Step 7

If no errors occur, the **Payment Calculation Question 2 screen** displays.

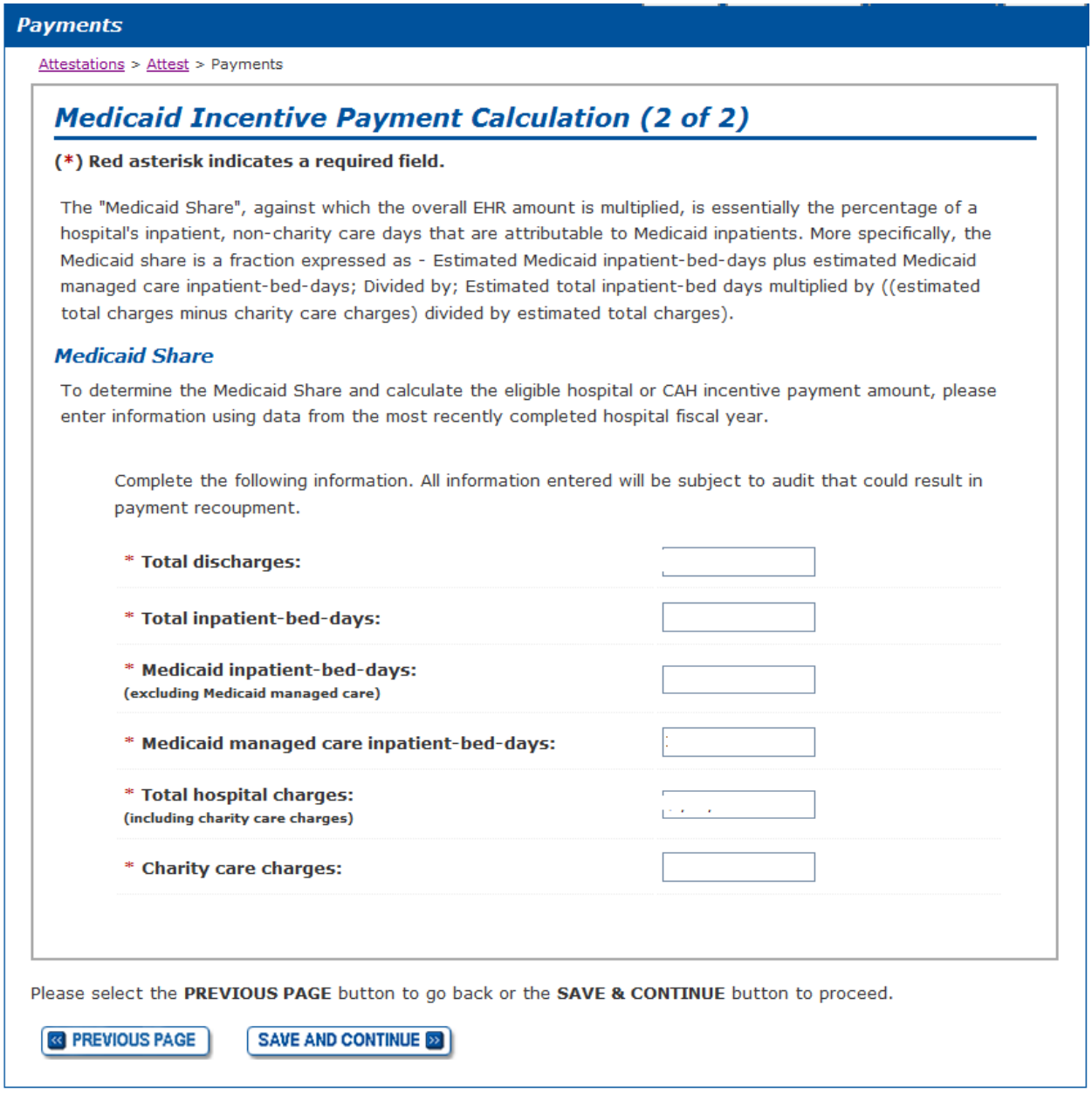


Figure 35 - Payment Calculation Question 2 Example

1. **Enter Total discharges**
   - ❑ Do not add commas. System will format with commas after entry.

2. **Enter total inpatient-bed-days**
   - Do not add commas. System will format with commas after entry.
3. **Enter Medicaid inpatient-bed-days**
   - Do not add commas. System will format with commas after entry.
4. **Enter Medicaid managed care inpatient-bed-days**
   - This is a required field. Enter 0 if manage care inpatient-bed-days do not apply.
   - Do not add commas. System will format with commas after entry.
5. **Enter total hospital charges**
   - Do not add commas. System will format with commas after entry.
6. **Enter charity care changes**
   - Do not add commas. System will format with commas after entry.
7. **Step 7: Select Save and Continue button**

   The system validates if all fields have data entered.

   If errors occur,

Supply numbers for each field. Please enter the appropriate data.

Execute Step 7

If no errors occur, the Payment Schedule screen displays.

10.4.3 Attestation Payment Schedule

This section identifies the steps to add the data to calculate the potential payment to the hospital. A facility representative will enter in the required information in the payment screens, which are described below. The system will calculate the amount for the organization based on the information that was entered.

10.4.3.1 Hospital Payment Calculation Formula

The hospital payment calculation formula was created by CMS.

STEP 1: Calculate the EHR amount

EHR Amount = ($2,000,000 + ($200.00*Total Discharges))*transition factor

The sum of the calculation will be performed in a hypothetical 4 year period.

The base amount of $2,000,000 plus the discharge related amount = $200 for the 1,150th through the 23,000th discharge for each 12 month period.) The solution does not consider discharges less

than 1,150 or over 23,000. If the number is over 23,000, the solution will use 23, 000 as the total discharges number for the equation. If the number is below 1, 150, the solution will assign 0 as the total discharge amount.

Multiplied by: the transition factor for the year:

- 1 – for Year 1
- 3/4 – for Year 2
- 1/2 – for Year 3
- 1/4 – for Year 4

Step 2: Calculate Medicaid Share

Medicaid Share = (Estimated Medicaid inpatient-bed-days + estimated Medicaid managed inpatient-bed-days) divided by: (Estimated total inpatient-bed-days * (estimated total charges – charity care charges)) divided by estimated total charges.

Step 3: Multiply the EHR Amount * Medicaid Share = Total Hospital Incentive Payment Amount

Example

Hospital A: ***Discharges 2000 in FY2010. Assume that for the four-year period of participation, Hospital A had 5,000 Medicaid inpatient-bed-days and 2,000 Medicaid managed care inpatient-bed-days. Its total inpatient-bed-days in FY 2010 were 21,000. Hospital A's total charges excluding charity care were $8,700,000, and its total charges for the period were $10,000,000. The annual growth data for the last three years of available data are: FY 2005 — .022 annual growth rate FY 2006 — .025 annual growth rate FY 2007 — .017 annual growth rate.***

The average growth rate is 022+.025+.017/3=.0213.

Total discharges are calculated as: 2000*1.0213=2043, 2043*1.0213=2087, 2087*1.0213=2131

Hospital A's aggregate EHR amount would be $2,069,936.00.

It was calculated as follows:

Initial Amount (with annual growth rate factored in to the number of discharges) * Transition Factor Year 1—$2,170,200 = {2,000,000 + [(2,000–1,149) * 200]} * 1

Year 2—$1,634,100 = {2,000,000 + [(2,043–1,149) * 200]} * .75

Year 3—$1,093,800 = {2,000,000 + [(2,087–1,149) * 200]} * .50

Year 4—$549,100 = {2,000,000 + [(2,131–1,149) * 200]} * .25

Overall EHR Amount = $5,447,200

Medicaid Share – 0.38 = ([5,000 + 2,000] divided by [21,000 x (8,700,000/10,000,000)])

Aggregate EHR Amount – $5,447,200 x 0.38 = $2,069,936.00

Please note, that DHS elected to have the total payment paid over a three year period utilizing the following:

- Year1 = 50%
- Year2 – 40%
- Year3 = 10%

Payments also have the following rules applied in the DHS Solution:

- The last year a hospital may begin receiving Medicaid incentive payments is 2016.
- Payments made over a minimum of 3 years and a maximum of 6 years.
- No annual payment may exceed 50% of the total calculation; no 2-year payment may exceed 90%.
- No annual payment may exceed 50% of the total calculation; no 2-year payment may exceed 90%

The payment schedule will display on the Payment Schedule screen as shown below in **Figure 36.**

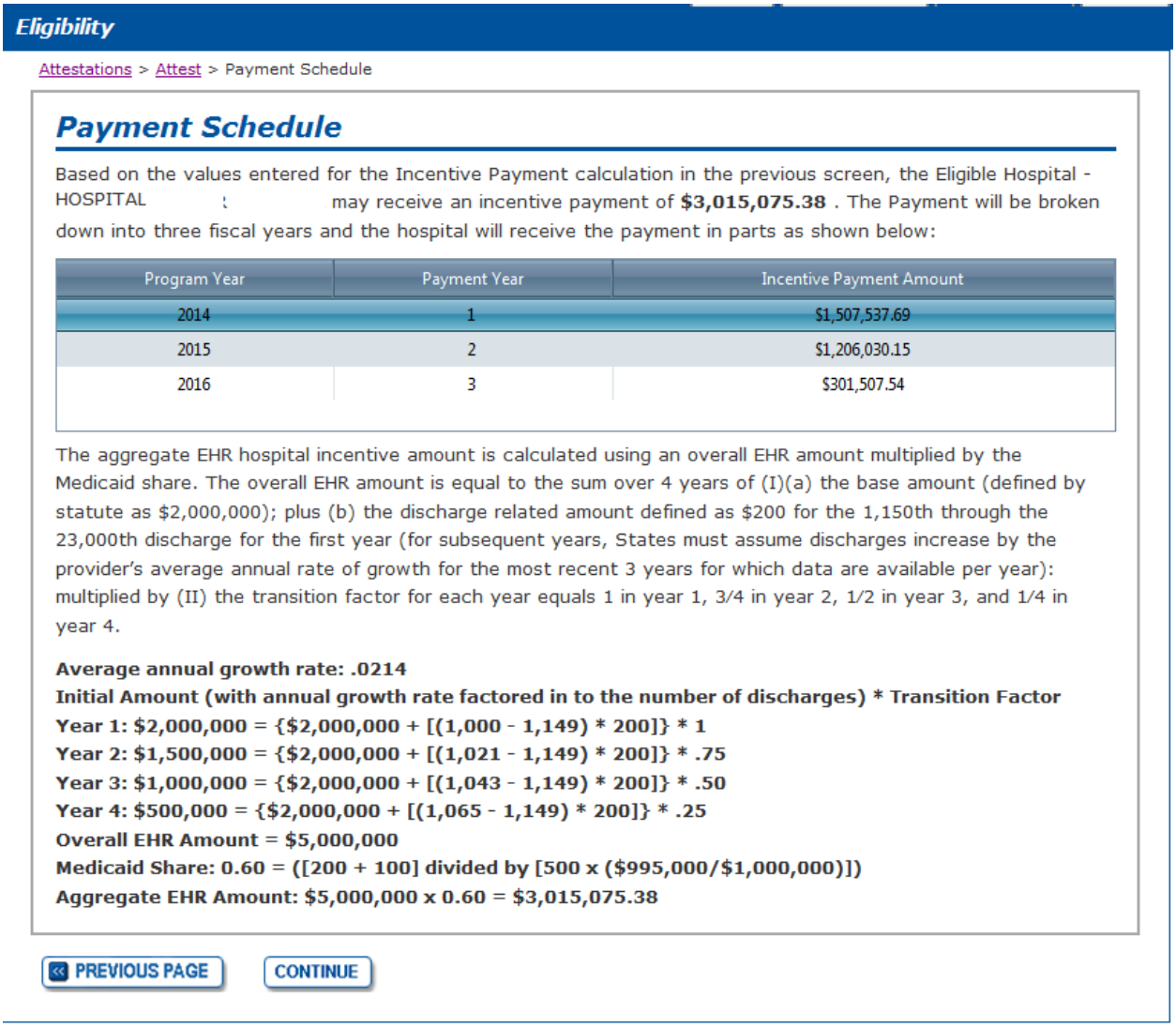


Figure 36 - Payment Schedule Example

1. Select Continue button to display the "Certified EHR Technology" page.
2. Select Previous Page button to display the "Eligibility" page.

10.4.4 Certified EHR Technology

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) is the body that tests and certifies electronic health record (EHR) systems. If the EHR system is approved, it is assigned a certification number. The website below is the Certified Health IT Product List website, http://onc-chpl.force.com/ehrcert, to look up your certified EHR technologies (CEHRT), add them to the cart, and then check out to obtain a EHR Certification Number for your CEHRT. The figure below is the attestation screen to enter in the EHR certification number for the system you are using.

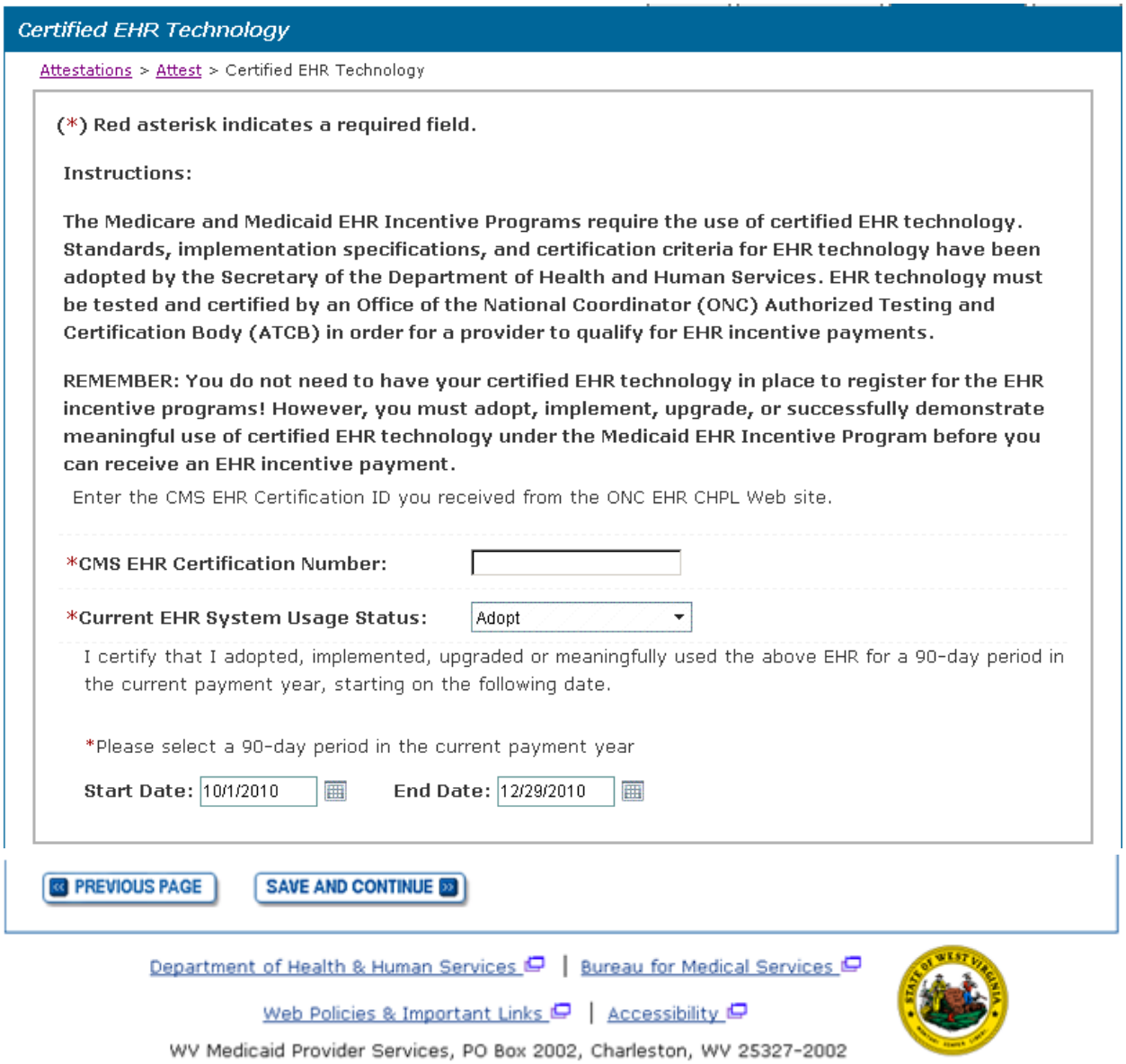


Figure 37 - CMS EHR Entry Example

1. Enter the ONC EHR Certification number
2. Select the option of adopted, implemented, upgraded, or meaningful use based on your EHR usage.
3. Select the 90 day period that the EHR system was adopted, implemented, or upgraded.

If AIU, select then

4. Select **Save and Continue**.

    - ❑ The system validates if all fields have data entered.
        - ❑ Error message displays if the user did not:
            - supply EHR Certification number
            - select an option
            - supply a 90 day start and end date
            - enter the appropriate data
        - ❑ If no errors occur, the Attestation Topic page displays. If all topics have been answered, the Submit button will be available.

If Meaningful Use 2013 or Meaningful Use 2014 is selected, then

4. Using the EHR Certification number, the system will validate if the EHR system is

    - ❑ 2011 Edition

        ❑Select Meaningful Use (2013 Stage 1) in dropdown

    - ❑ Combination of 2011 and 2014 Editions

        ❑Select either Meaningful Use (2013 Stage 1) or Meaningful Use (2014 Stage 1) in dropdown

    - ❑ 2014 Edition

        Select Meaningful Use (2014 Stage 1) in dropdown.

5. Answer questions as shown in the figure below.

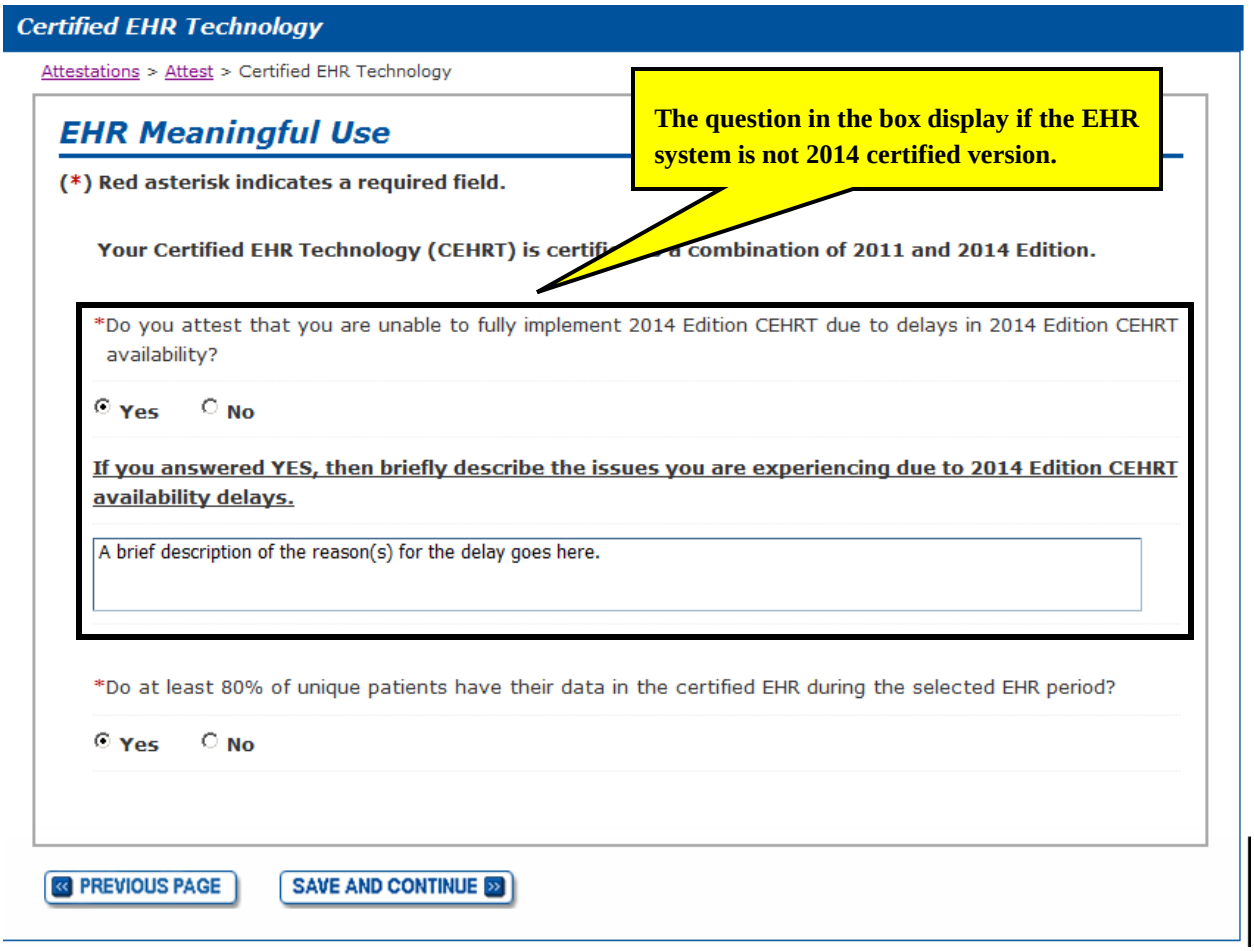


Figure 38 - EHR Certification Question Example

6. Confirm that 80% of patients records are in an certified EHR
    - ❑ If response is No, attestation progress halts.
7. Select Save and Continue button.

    The system validates that all fields have data entered.

    Error message displays if you did not:
    - ❑ supply EHR Certification number
    - ❑ select an required option
    - ❑ supply a 90 day start and end date

If Meaningful Use was selected, the user will need to respond to the meaningful use questions.

If AIU is selected, the user is able to submit the attestation

11. Meaningful Use

If the hospital selected "Meaningful Use" in the EHR Certified Technology page, the EP will need to provide responses to the meaningful use sections as outlined in the sections below. Each year 2013 and 2014 measures are listed in the sections below.

11.1 Meaningful Use Core Measures

The following sections show the 2013 and 2014 Meaningful Use Core Measures.

11.1.1 2013 Meaningful Use Core Measures

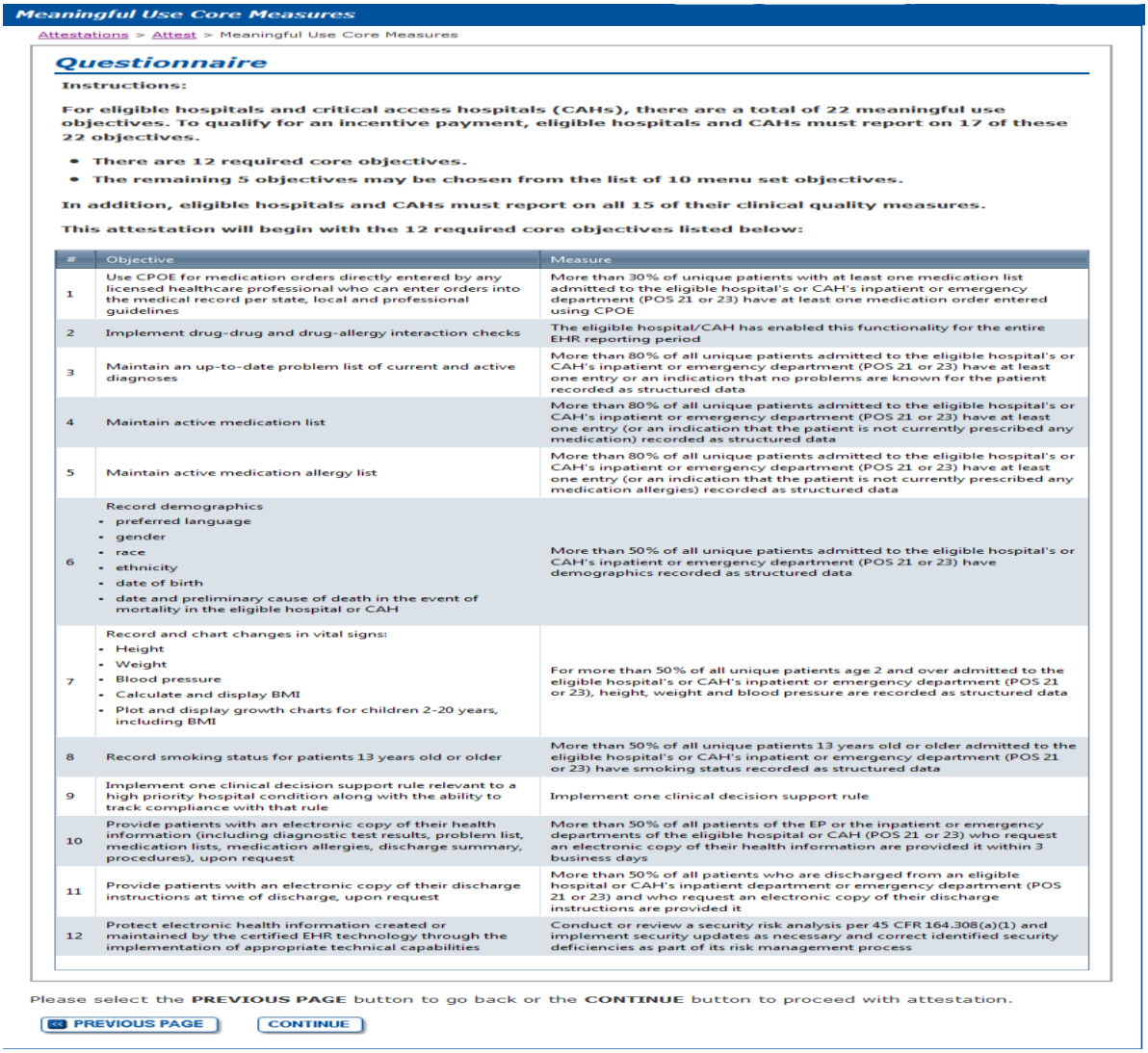
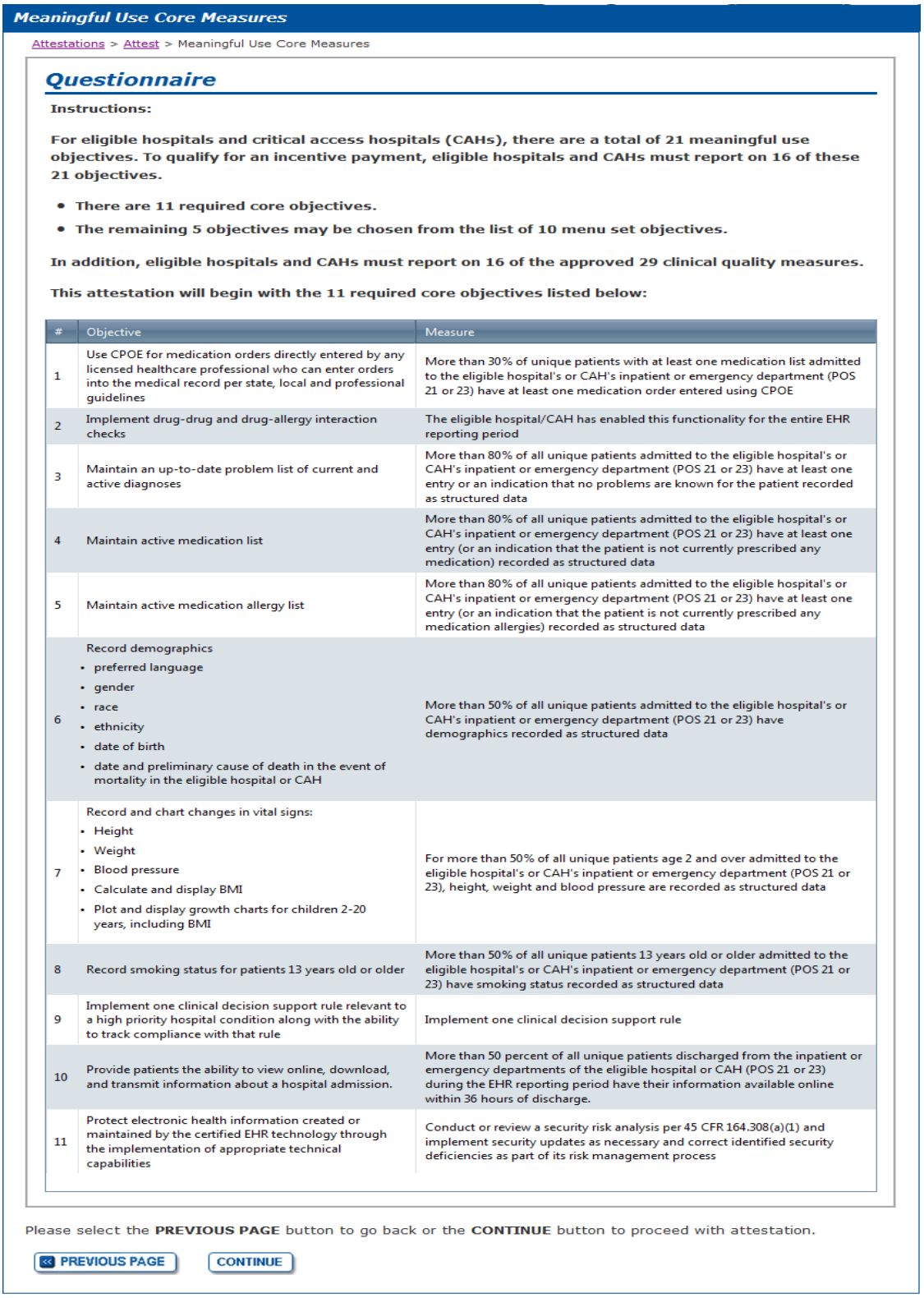


Figure 39 - 2013 Meaningful Use Core Measures

11.1.2 2014 Meaningful Use Core Measures



Meaningful Use Core Measures

Attestations > Attest > Meaningful Use Core Measures

Questionnaire

Instructions:

For eligible hospitals and critical access hospitals (CAHs), there are a total of 21 meaningful use objectives. To qualify for an incentive payment, eligible hospitals and CAHs must report on 16 of these 21 objectives.

- **There are 11 required core objectives.**
- **The remaining 5 objectives may be chosen from the list of 10 menu set objectives.**

In addition, eligible hospitals and CAHs must report on 16 of the approved 29 clinical quality measures.

This attestation will begin with the 11 required core objectives listed below:

#	Objective	Measure
1	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
2	Implement drug-drug and drug-allergy interaction checks	The eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
3	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
4	Maintain active medication list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
5	Maintain active medication allergy list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication allergies) recorded as structured data
6	Record demographics • preferred language • gender • race • ethnicity • date of birth • date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
7	Record and chart changes in vital signs: • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI	For more than 50% of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data
8	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
9	Implement one clinical decision support rule relevant to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule
10	Provide patients the ability to view online, download, and transmit information about a hospital admission.	More than 50 percent of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period have their information available online within 36 hours of discharge.
11	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Please select the **PREVIOUS PAGE** button to go back or the **CONTINUE** button to proceed with attestation.

PREVIOUS PAGE CONTINUE

Figure 40 - 2014 Meaningful Use Core Measures

11.1.3 Meaningful Use Core Question General Workflow Functionality

Link to CMS definition

- Regardless of 2013 or 2014, each meaningful use measure screen has a link to the CMS definition for the applicable requirements and detail of each measure for the EP to access and review the specific requirements for completing the numerator/denominator for each measure and, if applicable, the criteria for being exempt from the particular meaningful use measure.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not completed, the page will continue to display until required fields are corrected.
  - If required fields are completed, the next screen displays.

Previous Button

- Displays the previous screen.

11.2 Meaningful Use Menu Measures

CMS requires that the provider must select a minimum of five questions and one question must be a public health question for any of the selected option of 2013 Meaningful Use, 2011 CEHRT or a combination of 2011 and 2014 CEHRT, or 2014 MU Stage 1.

11.2.1 2013 Meaningful Use Menu Measures

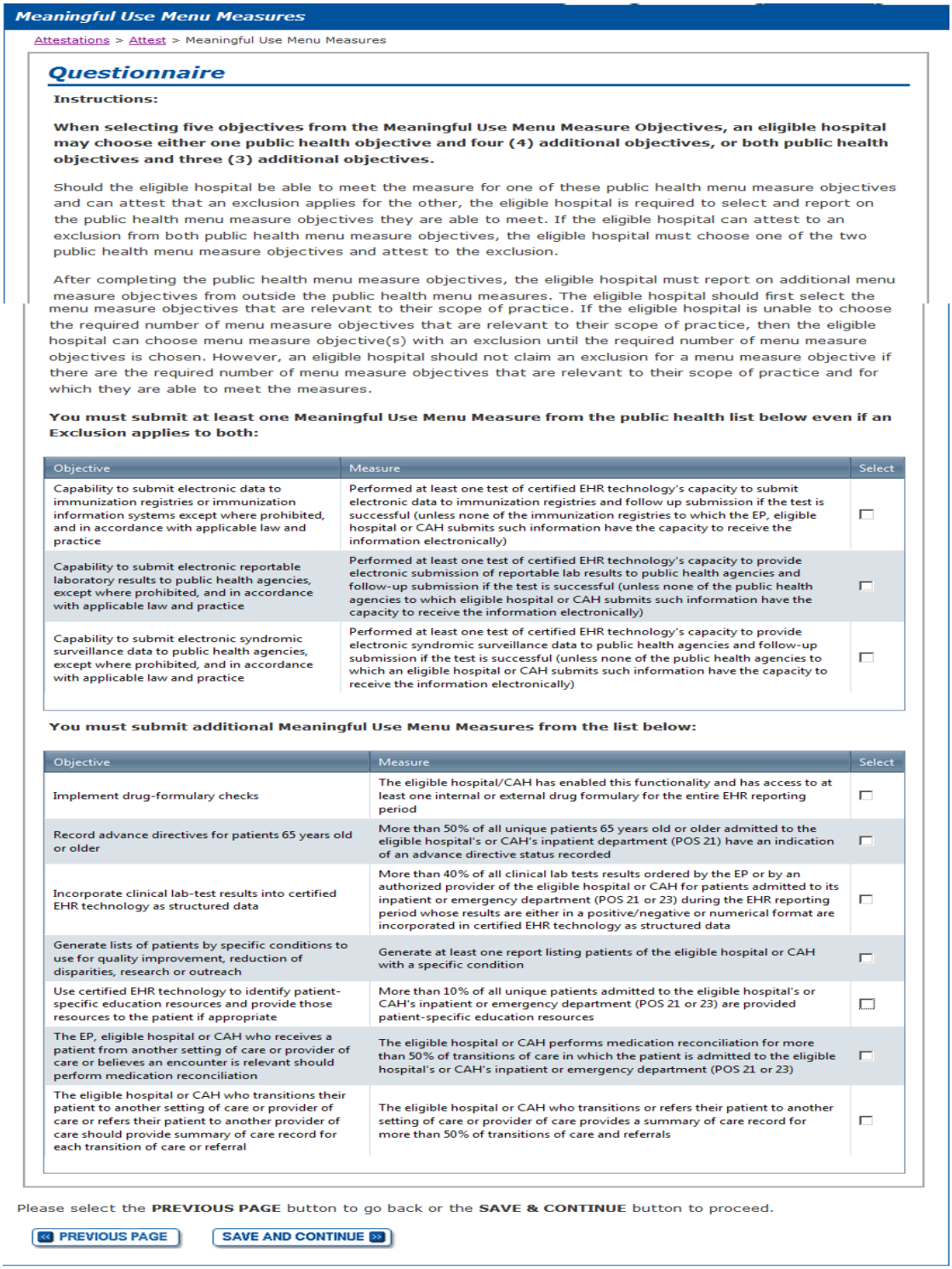


Figure 41 - 2013 Meaningful Use Menu Measures

11.2.2 2014 Meaningful Use Menu Measures

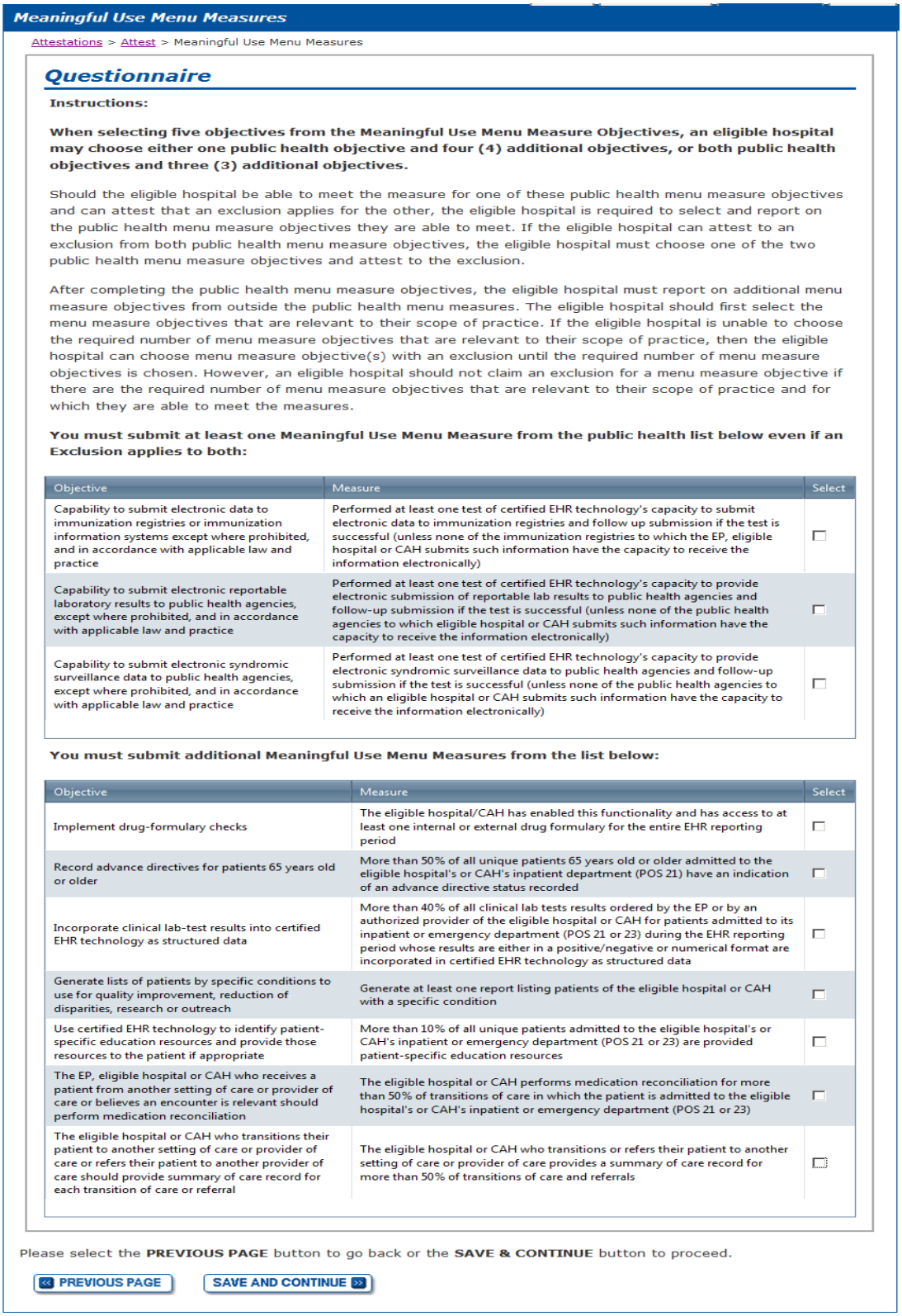


Figure 42 - 2014 Meaningful Use Menu Measures

11.2.3 Meaningful Use Question General Workflow Functionality

- User must select at least one public health question and remaining questions to respond to by clicking in the box under the SELECT column for each question.
- A checkmark indicates that you have selected that question. The application will allow you to select more than the minimum 5 questions.

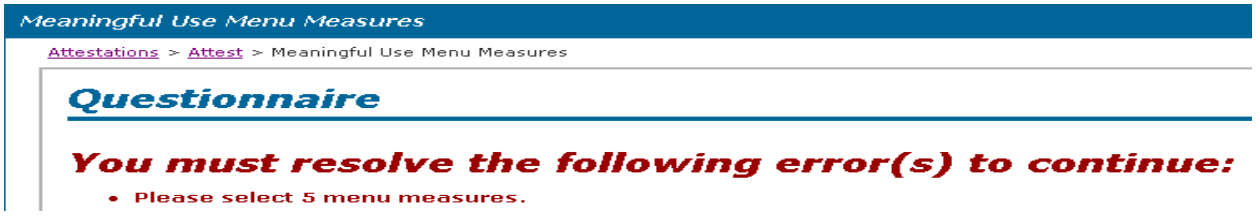
The following are the error messages if the minimum requirements are not meant:

MESSAGE 1- User receives the following error and cannot continue attestation process until error is fixed.

- If user does not select any questions
- If user does not select any public health question

MESSAGE 2 - User receives the following error and cannot continue attestation process until error is fixed.

- If the user selects less than 5 items, which includes a public health question, the following error message displays.



The application will only display the questions that were selected. The navigation is the same as was outlined in the Meaningful Use Core Measures section, as shown again below.

The application will not validate if the required score has been met at the time of entry, it will only tell the user if the appropriate questions have been completed or not. **The validation of meaningful use measures percentages is done after the attestation is submitted.**

Link to CMS definition

- Each meaningful use measure screen has a link to the CMS definition for the applicable requirements and detail of each measure for the EP to access and review the specific requirements for completing the numerator/denominator for each measure and, if applicable, the criteria for being exempt from the particular meaningful use measure.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not completed, the page will continue to display until required fields are corrected.
  - If required fields are completed, the next screen displays.

Previous Button

- Displays the previous screen.

11.3 Meaningful Use Clinical Quality Measures

CMS instructions for Clinical Quality Measure (CQMs) are for 2013 CQMs which the provider can select if they are using 2011 CEHRT or a combination of 2011 and 2014 CEHRT and they choose 2013 MU Stage 1. If the provider chooses 2014 MU Stage 1, the provider will address the 2014 CQMS.

11.3.1 2013 Meaningful Use Clinical Quality Measures

Attestations > Attest > Clinical Quality Measures

Questionnaire

Instructions:

Eligible hospitals and CAHs must report all 15 Clinical Quality Measures.

You must report on the 15 required CQMs listed below:

Identifier(s)	Clinical Quality Measure Title & Description
STK-2 NQF 0435	**Title:** Discharged on Antithrombolytic Therapy **Description:** Ischemic stroke patients prescribed antithrombolytic therapy at hospital discharge.
STK-3 NQF 0436	**Title:** Anticoagulation Therapy for Atrial Fibrillation/Flutter **Description:** Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.
STK-4 NQF 0437	**Title:** Thrombolytic Therapy **Description:** Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well.
STK-5 NQF 0438	**Title:** Antithrombolytic Therapy By End of Hospital Day 2 **Description:** Ischemic stroke patients administered antithrombolytic therapy by the end of hospital day 2.
STK-6 NQF 0439	**Title:** Discharged on Statin Medication **Description:** Ischemic stroke patients with LDL >= 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.
STK-8 NQF 0440	**Title:** Stroke Education **Description:** Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.
STK-10 NQF 0441	**Title:** Assessed for Rehabilitation **Description:** Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.
VTE-1 NQF 0371	**Title:** VTE Prophylaxis **Description:** This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
VTE-2 NQF 0372	**Title:** Intensive Care Unit (ICU) VTE Prophylaxis **Description:** This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).
VTE-3 NQF 0373	**Title:** Venous Thromboembolism (VTE) Patients with Anticoagulation Overlap Therapy **Description:** This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) >= 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.
VTE-4 NQF 0374	**Title:** Venous Thromboembolism (VTE) Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram) **Description:** This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.
VTE-5 NQF 0375	**Title:** Venous Thromboembolism Discharge Instructions **Description:** This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health or home hospice on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring and information about the potential for adverse drug reactions/interactions.
VTE-6 NQF 0376	**Title:** Incidence of Potentially-Preventable Venous Thromboembolism **Description:** This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.
ED-1 NQF 0495	**Title:** Median Time from ED Arrival to ED Departure for Admitted ED Patients **Description:** Median time (in minutes) from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.
ED-2 NQF 0497	**Title:** Admit Decision Time to ED Departure Time for Admitted ED Patients **Description:** Median time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.

Please select the **PREVIOUS PAGE** button to go back or the **CONTINUE** button to proceed.

PREVIOUS PAGE CONTINUE

Figure 43 - 2013 Meaningful Use Clinical Quality Measures

11.3.2 2014 Meaningful Use Clinical Quality Measures

Clinical Quality Measures

Attestations > Attest > Clinical Quality Measures

Questionnaire

Instructions:

Eligible hospitals and CAHs must report on 16 of the 29 approved Clinical Quality Measures. The selected CQMs must cover at least 3 of the National Quality Strategy domains.

You must submit 16 Clinical Quality Measures from the list below:
(You have selected 0 CQMs)

Identifier(s)	Clinical Quality Measure Title & Description	Domain	Select
CMS55v2 NQF 0495	**Title:** Emergency Department (ED)-1 Emergency Department Throughput – Median Time from ED Arrival to ED Departure for Admitted ED Patients **Description:** Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.	Patient and Family Engagement	☐
CMS111v2 NQF 0497	**Title:** ED-2 Emergency Department Throughput – Admitted Patients – Admit Decision Time to ED Departure Time for Admitted Patients **Description:** Median time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.	Patient and Family Engagement	☐
CMS104v2 NQF 0435	**Title:** Stroke-2 Ischemic Stroke – Discharged on Anti-thrombotic Therapy **Description:** Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.	Clinical Process/Effectiveness	☐
CMS71v3 NQF 0436	**Title:** Stroke-3 Ischemic Stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter **Description:** Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.	Clinical Process/Effectiveness	☐
CMS91v3 NQF 0437	**Title:** Stroke-4 Ischemic Stroke – Thrombolytic Therapy **Description:** Acute ischemic stroke patients who arrive at this hospital within 2 hours (120 minutes) of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours (180 minutes) of time last known well.	Clinical Process/Effectiveness	☐
CMS72v2 NQF 0438	**Title:** Stroke-5 Ischemic Stroke – Antithrombotic Therapy by End of Hospital Day Two **Description:** Ischemic stroke patients administered antithrombotic therapy by the end of hospital day two.	Clinical Process/Effectiveness	☐
CMS105v2 NQF 0439	**Title:** Stroke-6 Ischemic Stroke – Discharged on Statin Medication **Description:** Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.	Clinical Process/Effectiveness	☐
CMS107v2 NQF 0440	**Title:** Stroke-8 Ischemic or Hemorrhagic Stroke – Stroke Education **Description:** Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.	Patient and Family Engagement	☐
CMS102v2 NQF 0441	**Title:** Stroke-10 Ischemic or Hemorrhagic Stroke – Assessed for Rehabilitation **Description:** Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.	Care Coordination	☐
CMS108v2 NQF 0371	**Title:** Venous Thromboembolism (VTE)-1 VTE Prophylaxis **Description:** This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.	Patient Safety	☐
CMS190v2 NQF 0372	**Title:** VTE-2 Intensive Care Unit (ICU) VTE Prophylaxis **Description:** This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the ICU or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).	Patient Safety	☐
CMS73v2 NQF 0373	**Title:** VTE-3 VTE Patients with Anticoagulation Overlap Therapy **Description:** This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.	Clinical Process/Effectiveness	☐
CMS109v2 NQF 0374	**Title:** VTE-4 VTE Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram) **Description:** This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.	Clinical Process/Effectiveness	☐
CMS110v2 NQF 0375	**Title:** VTE-5 VTE Discharge Instructions **Description:** This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/ interactions.	Patient and Family Engagement	☐
CMS114v2 NQF 0376	**Title:** VTE-6 Incidence of Potentially Preventable VTE **Description:** This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	Patient Safety	☐
CMS100v2 NQF 0142	**Title:** AMI-2-Aspirin Prescribed at Discharge for AMI **Description:** AMI patients who are prescribed aspirin at hospital discharge.	Clinical Process/Effectiveness	☐
CMS113v2 NQF 0469	**Title:** PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation **Description:** Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.	Clinical Process/Effectiveness	☐
CMS60v2 NQF 0164	**Title:** AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival **Description:** Acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.	Clinical Process/Effectiveness	☐
CMS53v2 NQF 0163	**Title:** AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival **Description:** Acute myocardial infarction (AMI) Patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.	Clinical Process/Effectiveness	☐
CMS30v3 NQF 0639	**Title:** AMI-10 Statin Prescribed at Discharge **Description:** Acute Myocardial Infarction (AMI) patients who are prescribed a statin at hospital discharge.	Clinical Process/Effectiveness	☐
CMS188v3 NQF 0147	**Title:** PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients **Description:** Immunocompetent patients with CAP who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines.	Efficient Use of Healthcare Resources	☐
CMS171v3 NQF 0527	**Title:** SCIP-INF-1 Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision **Description:** Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received Vancomycin or a Fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within 2 hours prior to surgical incision. Due to the longer infusion time required for Vancomycin or a Fluoroquinolone, it is acceptable to start these antibiotics within 2 hours prior to incision time.	Patient Safety	☐
CMS172v3 NQF 0528	**Title:** SCIP-INF-2 Prophylactic Antibiotic Selection for Surgical Patients **Description:** Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	Efficient Use of Healthcare Resources	☐
CMS178v3 NQF 0453	**Title:** SCIP-INF-9 Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero **Description:** Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	Patient Safety	☐
CMS32v3 NQF 0496	**Title:** ED-3 Median Time from ED Arrival to ED Departure for Discharged ED Patients **Description:** Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.	Care Coordination	☐
CMS26v1 NQF 0338	**Title:** Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver **Description:** An assessment that there is documentation in the medical record that a Home Management Plan of Care document was given to the pediatric asthma patient/caregiver.	Patient and Family Engagement	☐
CMS9v2 NQF 0480	**Title:** Exclusive Breast Milk Feeding **Description:** Exclusive breast milk feeding during the newborn's entire hospitalization.	Clinical Process/Effectiveness	☐
CMS185v2 NQF 0716	**Title:** Healthy Term Newborn **Description:** Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or in nursery care.	Patient Safety	☐
CMS31v2 NQF 1354	**Title:** EHDI-1a Hearing Screening Before Hospital Discharge **Description:** This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.	Clinical Process/Effectiveness	☐

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Figure 44 - 2014 Meaningful Use Clinical Quality Measures

11.3.3 Clinical Quality Measures Meaningful Use Question General Workflow Functionality

To complete the CQM section, the required number of CQMs must be selected for the meaningful use year.

The following are the error messages if the minimum requirements are not meet.

MESSAGE - The error message displays the number of questions that need to be selected to meet the minimum requirement.

You must resolve the following error(s) to continue:

- Please select 3 Additional Clinical Quality Measures.

You must resolve the following error(s) to continue:

- Please select 2 more Additional Clinical Quality Measures.

You must resolve the following error(s) to continue:

- Please select 1 more Additional Clinical Quality Measure.

Link to CMS definition

- Each clinical quality measure screen has a link to the CMS definition for the applicable requirements and detail of each measure for the EP to access and review the specific requirements for completing the numerator/denominator for each measure and, if applicable, the criteria for being exempt from the particular clinical quality measure.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not completed, the page will continue to display until required fields are corrected.
  - If required fields are completed, the next screen displays.

Previous Button

- Displays the previous screen

11.4 Submit Attestation and payment status

The **Submit Attestation** button remains disabled if the attestation fails any eligibility checks or not all required questions have been answered. If the attestation passes all eligibility checks and all required questions are answered, the **Submit Attestation** button is available. On selection of the **Submit Attestation** button, the following screen displays:

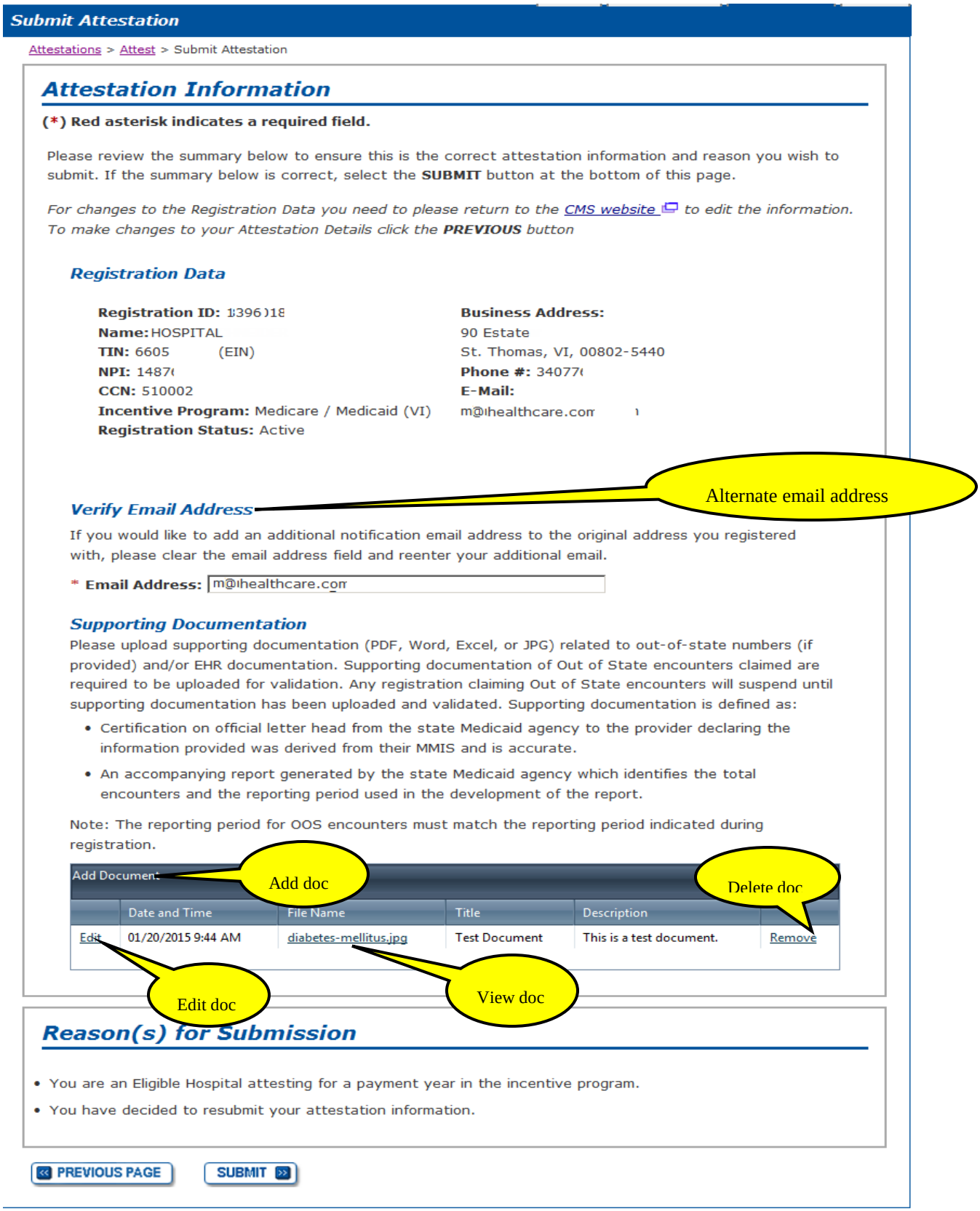


Figure 45 - Reason to Submit Attestation Example

11.4.1 Supporting Documentation

Documents supporting any of the information entered into the Attestation Application may be uploaded here. Documents may be in the form of PDF, Jpeg, Microsoft Excel, and Microsoft Word files and must be 4 megabytes or smaller. Section 3 of this document lists required documentation. If you have entered out-of-state encounters, you are required to upload two documents, which are a certification letter that patient volumes entered are from the other state's MMIS and the report from the state's MMIS.

- ❑ To add a document
  - Select **Add Document** to display the following screen

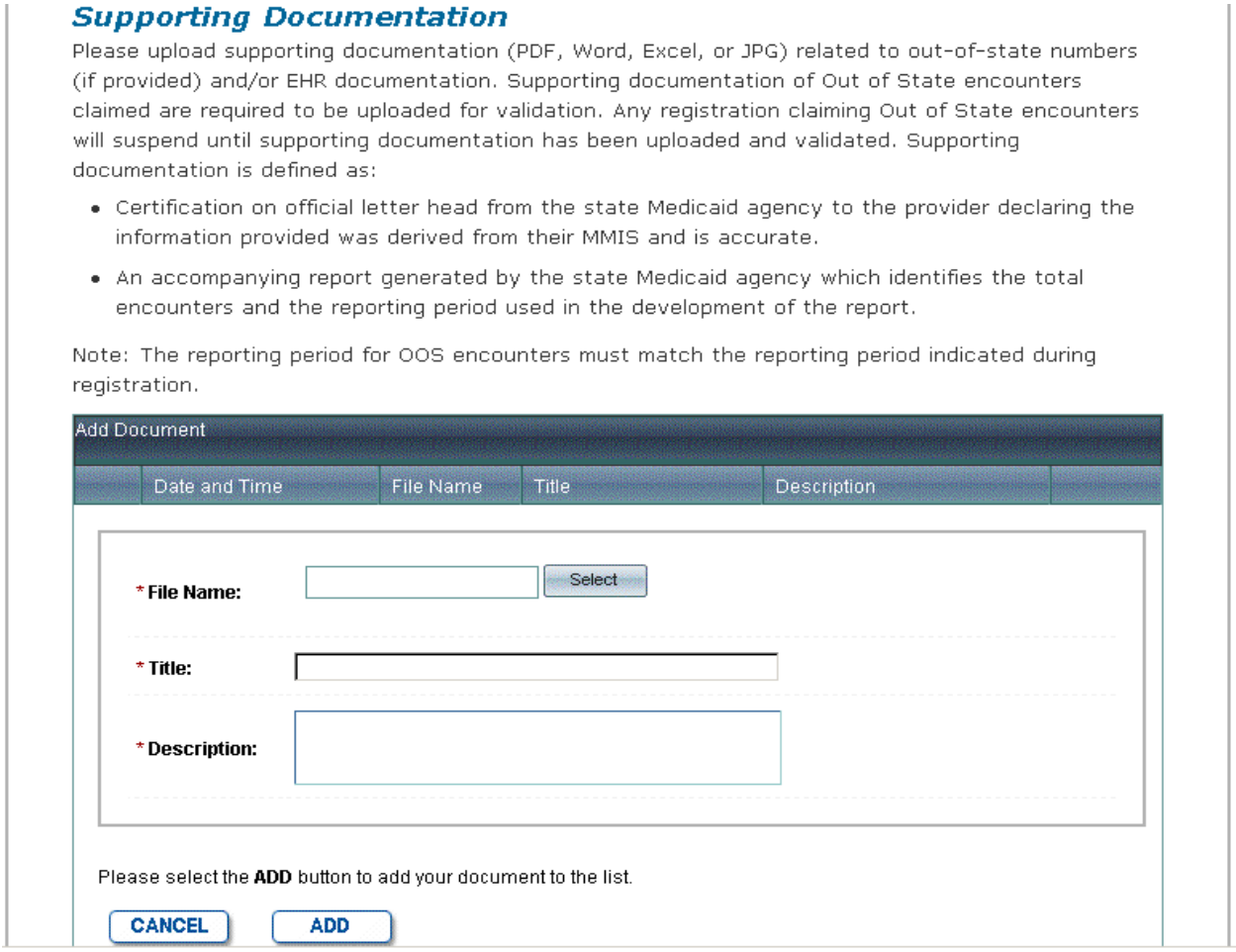


Figure 46 - Supporting Documentation - Add Screen Example

- ❑ Select "File to Upload" from your computer

  Select the **Select** button

On Files window, navigate through your folders and select the file to upload,

Select **Ok**.

Document name displays in the File Name box.

- ❑ Enter in Title
- ❑ Enter in Description of file
- ❑ Select **Add**
- ❖ To add more files, Repeat Steps.

To edit a document

- ❑ Select **Edit** next to the desired document
- ❑ The "Supporting Documentation – Add" screen fields displays with **Update** and **Cancel** buttons instead.
- ❑ Modify the information
- ❑ Select **Update**

To delete document

- ❑ Select **Remove** next to the desired document
- ❑ Answer "Are you sure?" question appropriately

Select **Submit** button. This displays the "Successful Submission" Page. An example is below.

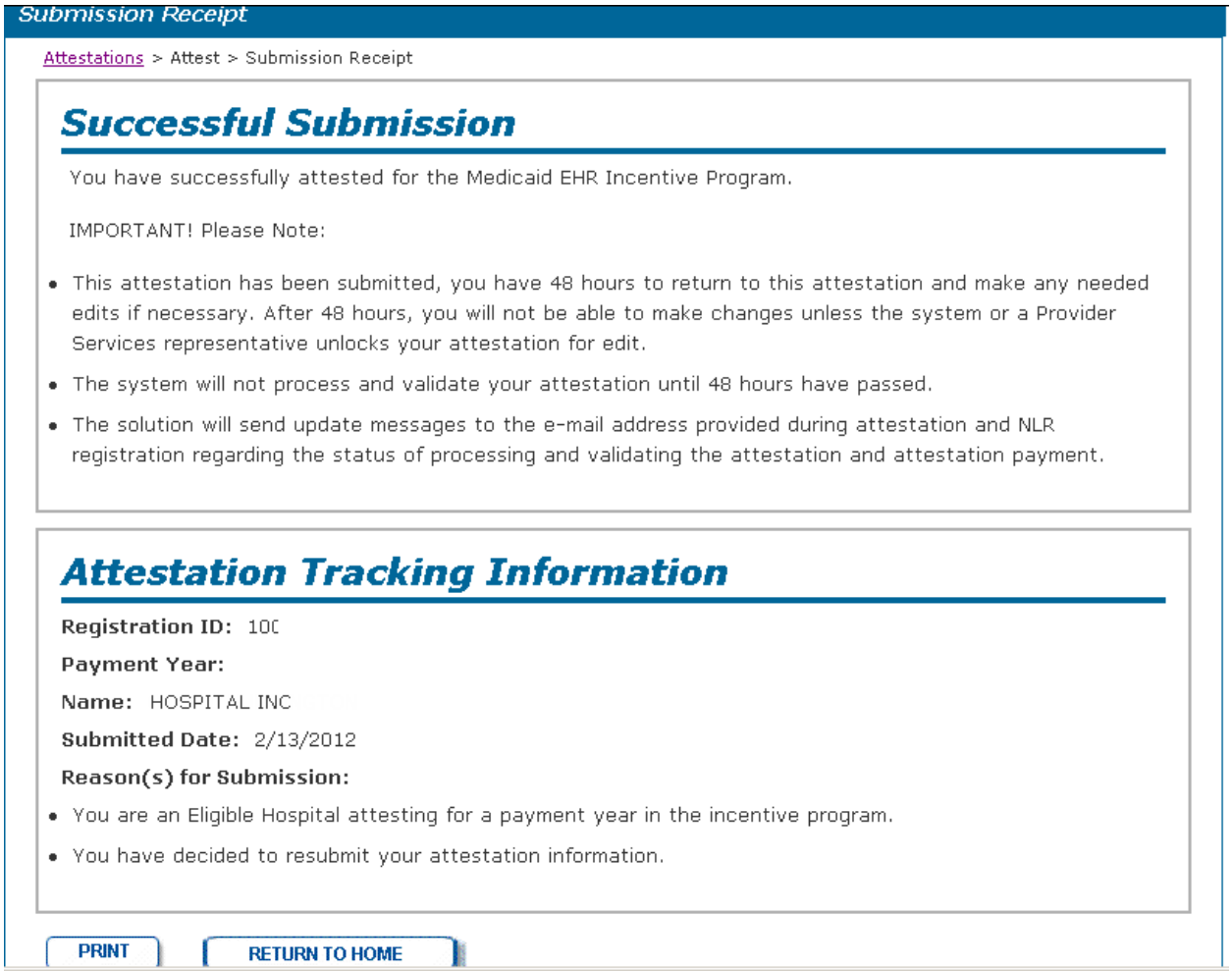


Figure 47 - Submission Receipt Window Example

Upon the successful submission of the uploaded documents, the attestation entry process is completed. The USVI Medicaid EHR Incentive Program provides 48 hours to make changes. If changes are made during the initial 48 hour period, a new 48 hour period will begin. Once no changes are made to an attestation for 48 hours, the USVI Medicaid EHR Incentive Program Attestation Application will execute its final eligibility checks. These include validating that the Medicaid patient encounter counts entered by the EP are within a reasonable range of the fee-for-service stored in the USVI MMIS and querying the CMS NLR to determine if the attesting EP has already received an EHR Incentive Program payment from the Medicare EHR Incentive Program or another state's Medicaid EHR Incentive Program. This processing will take some time to complete, and payments will not be sent immediately after submitting a completed attestation.

After the eligibility and payment checks are executed, the USVI Medicaid EHR Incentive Program will send the EP an e-mail with their current attestation status. If an eligibility or

payment error has occurred during the initial data verification process and assistance is needed, please contact the USVI Medicaid Provider Services Help Desk at 855-248-7536 option 2.

The USVI Medicaid EHR Incentive Program Attestation Application will describe the attestation errors. Alternatively, EPs can log in to the application and select the "Status" tab to display their current attestation status.

12. References

http://www.cms.gov/QualityMeasures/Downloads/QMGuideForReadingEHR.pdf

13. Status Grid

The table lists the attestation status that may occur.

Provider Screen Status	Admin Portal Attestation Status	Description - Provider
Attestation Not Allowed	Attestation Not Allowed	Provider's registration did not pass the inital eligibility check.
Attestation Not Started	Attestation Not Started	Provider's registration has processed successful; but the provider has not yet logged into the PIP solution and begun their attestation
Attestation In Progress	Attestation In Progress	Provider has opened their attestation and is actively editing it.
Submitted	Submitted	This status appears after submission for 48 hrs till final provider eligibility check is run. Provider can cancel an attestation and re-edit it for 2 days after submission prior to it being "finalized"
Pended	Pended	Provider sees "Pended"
Provider has failed final Elg check • POS Error • Volume error • Pay hold error	Resubmit	Provider sees "Resubmit" and the appropriate reason message for the eligibility error
Accepted	Accepted	Provider will see their attestation on the Status tab. The status will be Accepted
• Locked for Payment • Excluded from payment	Locked For Payment Excluded From Payment	Attestation remains on the Status tab only. Waiting for payment validation from NLR

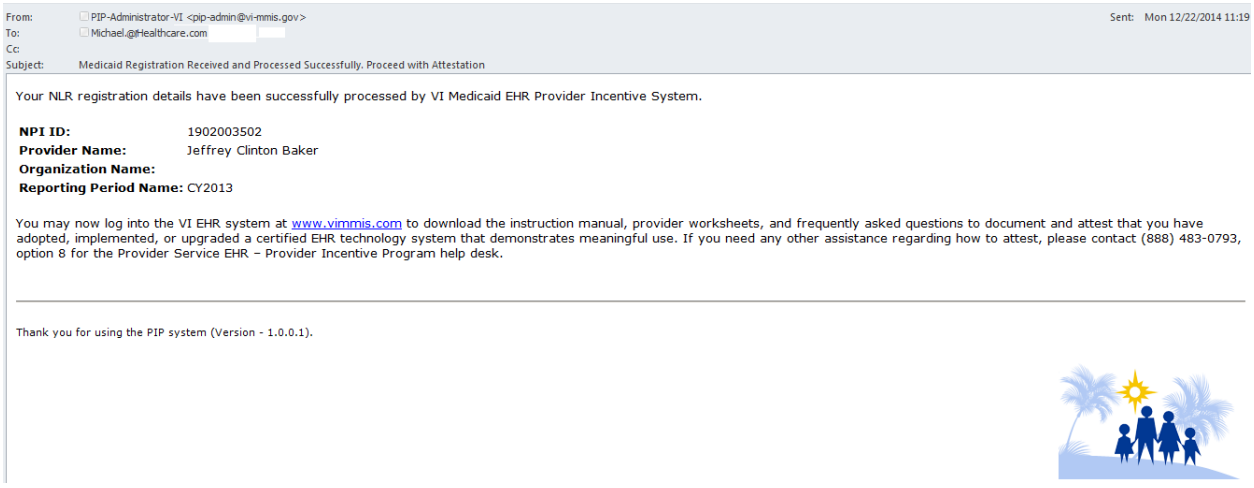
Figure 48 - Attestation Status Grid Example

14. Successful Registration with CMS Email

After registering with CMS, it may take 48 hours before this message is received.

- The delay is for CMS processing registration and sending them to the appropriate State repository. The Provider Portal application will receive the registration in the State repository and process registration. The Provider Portal application checks that the provider is a valid provider type and has active enrollment in Medicaid.

When this message is received, log into the Provider Portal to register and attest.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:19
To: Michael.@Healthcare.com
Cc:
Subject: Medicaid Registration Received and Processed Successfully. Proceed with Attestation

Your NLR registration details have been successfully processed by VI Medicaid EHR Provider Incentive System.

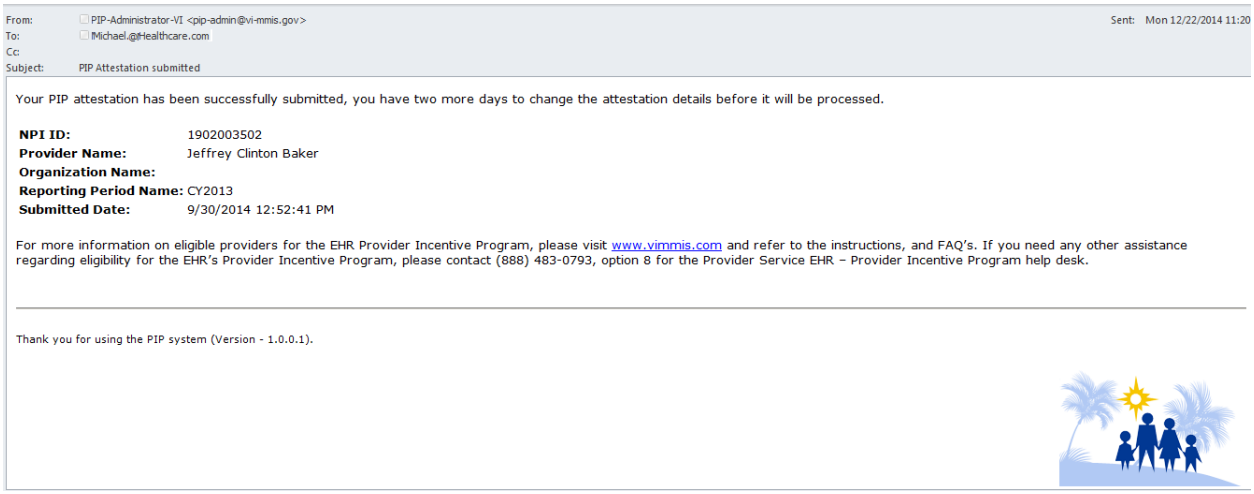
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013

You may now log into the VI EHR system at www.vimmis.com to download the instruction manual, provider worksheets, and frequently asked questions to document and attest that you have adopted, implemented, or upgraded a certified EHR technology system that demonstrates meaningful use. If you need any other assistance regarding how to attest, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

15. Submitted Attestation Email

This email is sent after submitting the attestation. The Attestation Application will allow EHs to make changes to a submitted attestation for 48 hours. After 48 hours have passed from the last attestation change, the system will execute its final edits.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
Sent: Mon 12/22/2014 11:20
To: IMichael.@Healthcare.com
Cc:
Subject: PIP Attestation submitted

Your PIP attestation has been successfully submitted, you have two more days to change the attestation details before it will be processed.

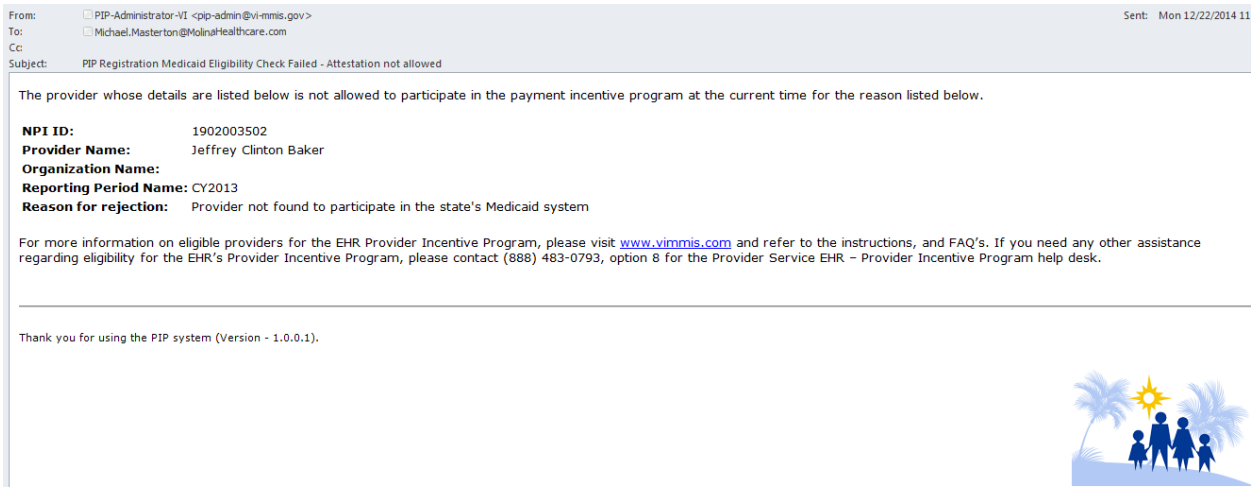
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

16. Error occurred when processing registration Email

When the Attestation Application receives a registration from the National Level Repository (NLR), it must validate the EH's Medicaid EHR Incentive Program eligibility. The email below is sent if the EH does not exist in the MMIS.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.

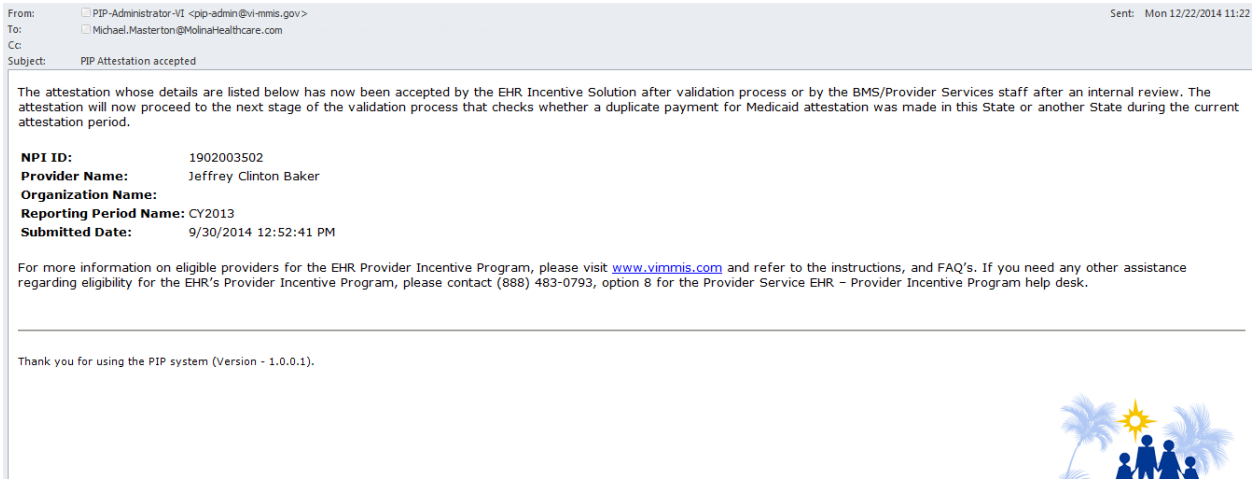
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Reason for rejection: Provider not found to participate in the state's Medicaid system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

17. Attestation Accepted Email

This email is sent when the 48 hours allowed for attestation changes have expired. The attestation is no longer accessible for changes within the application. The attestation details will be sent to the NLR to check if any other EHR Incentive Program payments have been made for the attesting EH for the given payment year.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:22
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation accepted

The attestation whose details are listed below has now been accepted by the EHR Incentive Solution after validation process or by the BMS/Provider Services staff after an internal review. The attestation will now proceed to the next stage of the validation process that checks whether a duplicate payment for Medicaid attestation was made in this State or another State during the current attestation period.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM

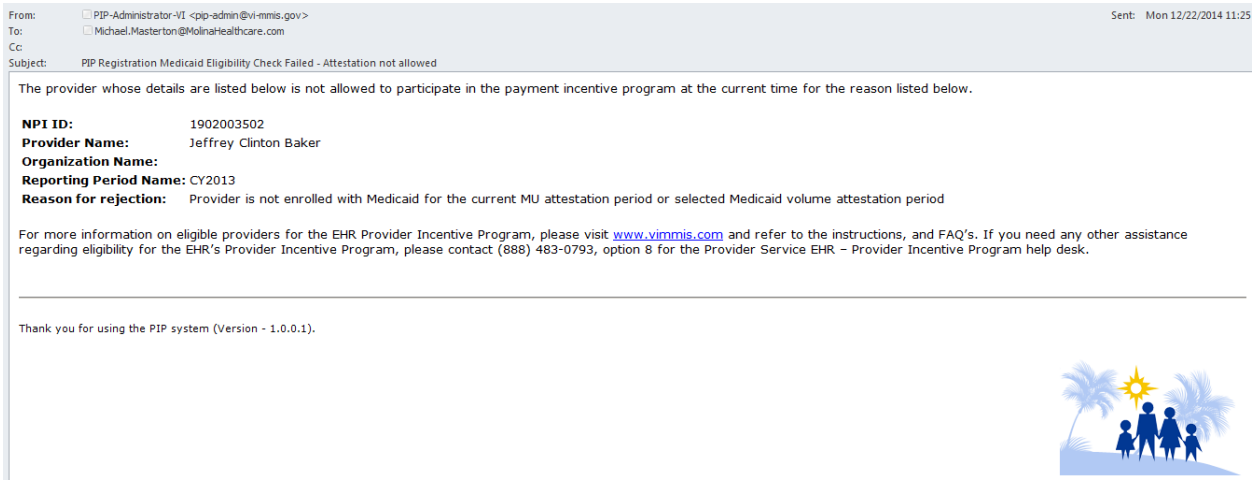
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

18. Error Occurred While Processing Registration – Medicaid Enrollment failed Email

The following checks are made when an attestation is received from the NLR. The email below displays all the possible error messages for the following checks.

8. Check if the provider is enrolled in Medicaid program during the attestation period.
9. Check if the provider type that was selected when registering on the CMS site matches the provider type on the provider's enrollment record.
10. Check if the payee NPI entered when registering on the CMS site is found when validating the attesting provider's payees on the Medicaid record.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:25
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.

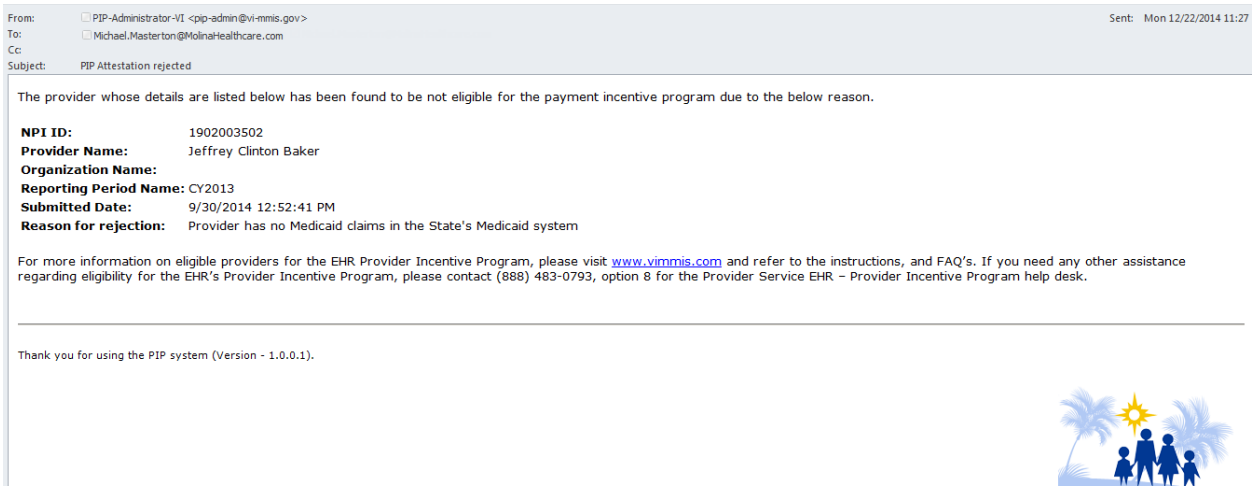
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Reason for rejection: Provider is not enrolled with Medicaid for the current MU attestation period or selected Medicaid volume attestation period

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

19. Attestation Error – Medicaid Claims count failed Email

The solution will check the provider's Medicaid claims that were submitted during the attestation period. If there were no claims found for the attestation period, the following email will be sent.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:27
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected

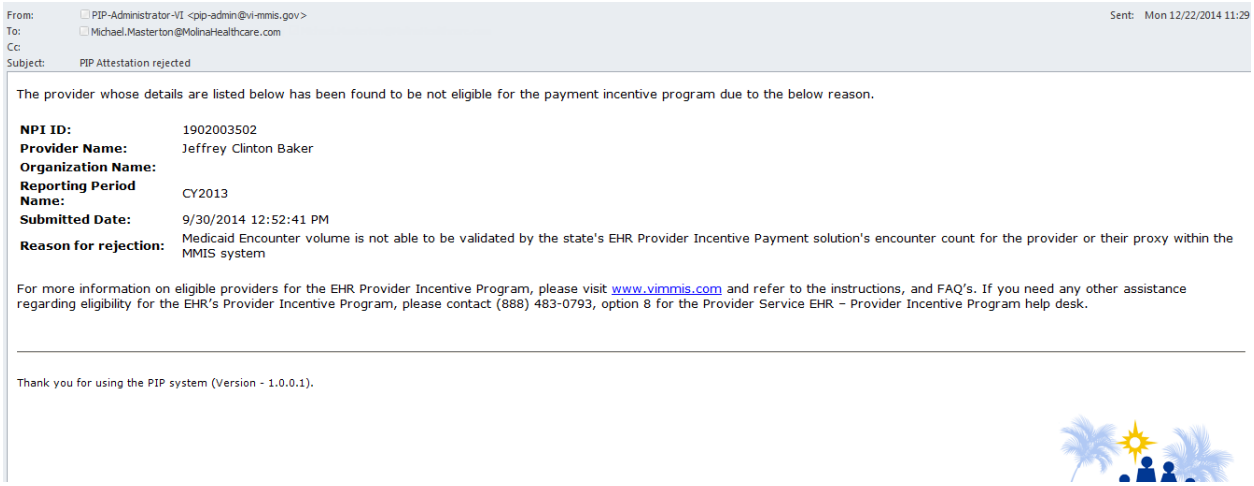
The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for rejection: Provider has no Medicaid claims in the State's Medicaid system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

If the solution found that claims counts could not be validated, then the following email is sent.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:29
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

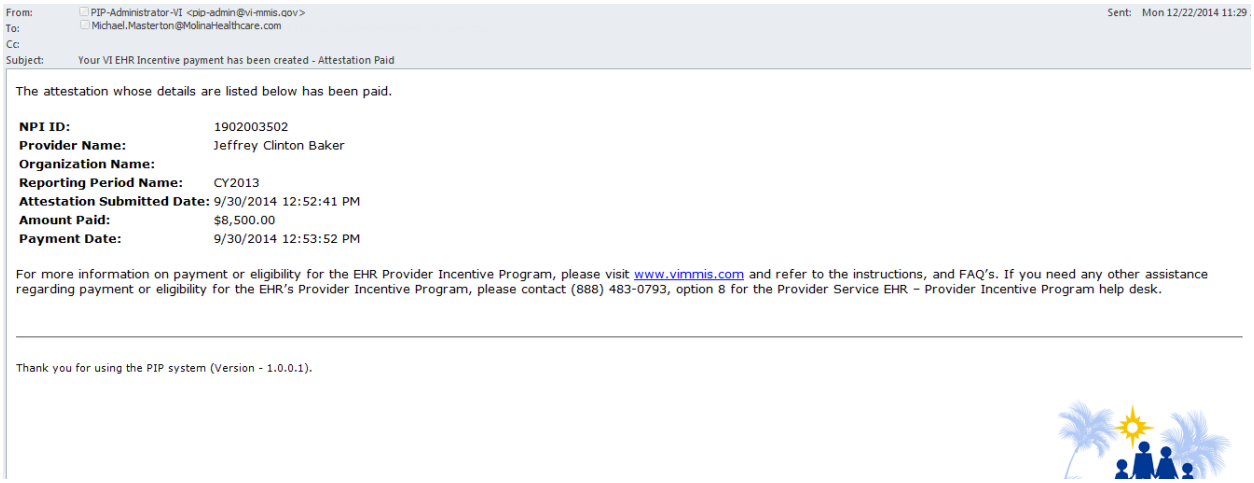
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for rejection: Medicaid Encounter volume is not able to be validated by the state's EHR Provider Incentive Payment solution's encounter count for the provider or their proxy within the MMIS system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

20. Attestation Paid Email

If final eligibility checks pass and no payment issues occurred, an email is sent indicating that payment is approved and being processed. The payment will continue with additional processing, so payment arrival will take a few days.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:29
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: Your VI EHR Incentive payment has been created - Attestation Paid

The attestation whose details are listed below has been paid.

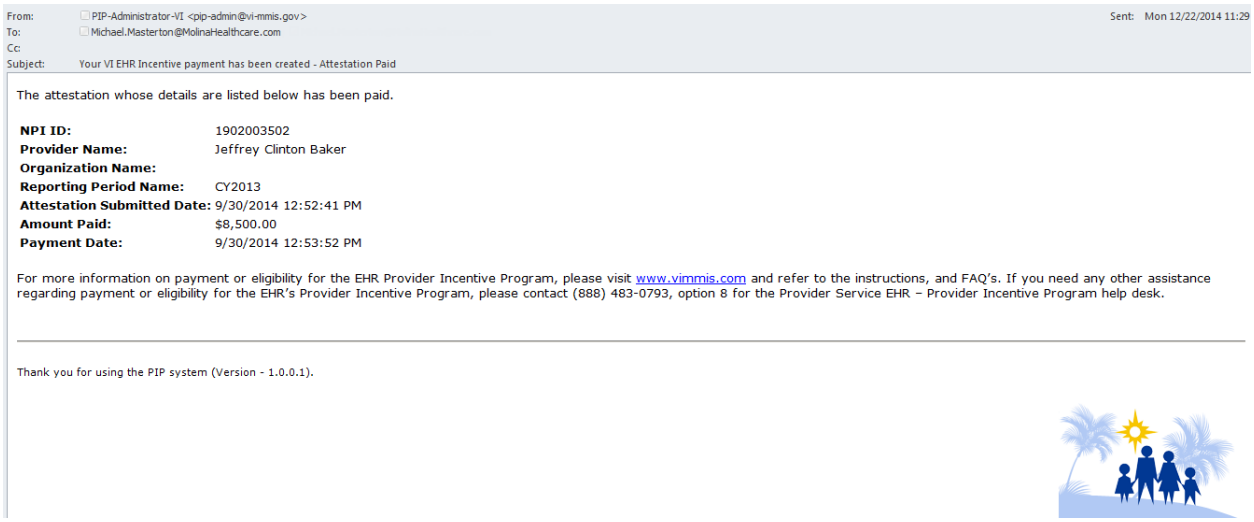
NPI ID:	1902003502
Provider Name:	Jeffrey Clinton Baker
Organization Name:	
Reporting Period Name:	CY2013
Attestation Submitted Date:	9/30/2014 12:52:41 PM
Amount Paid:	$8,500.00
Payment Date:	9/30/2014 12:53:52 PM

For more information on payment or eligibility for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding payment or eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

21. Attestation Payment Denied Email

If final eligibility checks did not pass and payment issues occurred, an email indicating denial is sent. The Medicaid Provider Services staff at 855-248-7536 option 2 may be able to address questions.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:29
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: Your VI EHR Incentive payment has been created - Attestation Paid

The attestation whose details are listed below has been paid.

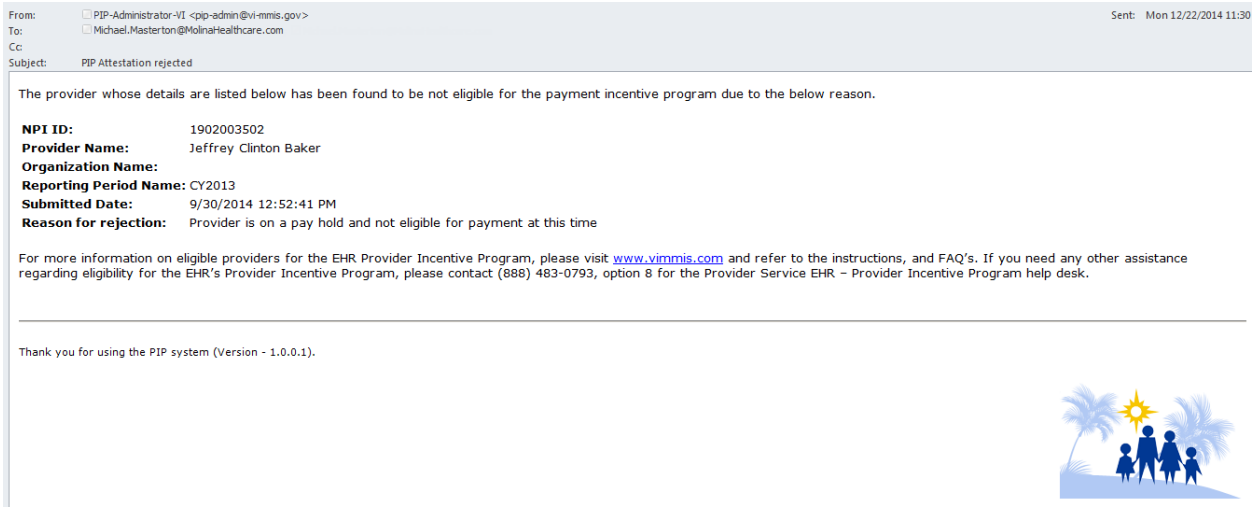
NPI ID:	1902003502
Provider Name:	Jeffrey Clinton Baker
Organization Name:	
Reporting Period Name:	CY2013
Attestation Submitted Date:	9/30/2014 12:52:41 PM
Amount Paid:	$8,500.00
Payment Date:	9/30/2014 12:53:52 PM

For more information on payment or eligibility for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding payment or eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

22. Attestation Payment Denied – Pay Hold found

Payment is denied if the provider is on pay hold and this email is sent if it is found.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected
Sent: Mon 12/22/2014 11:30

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

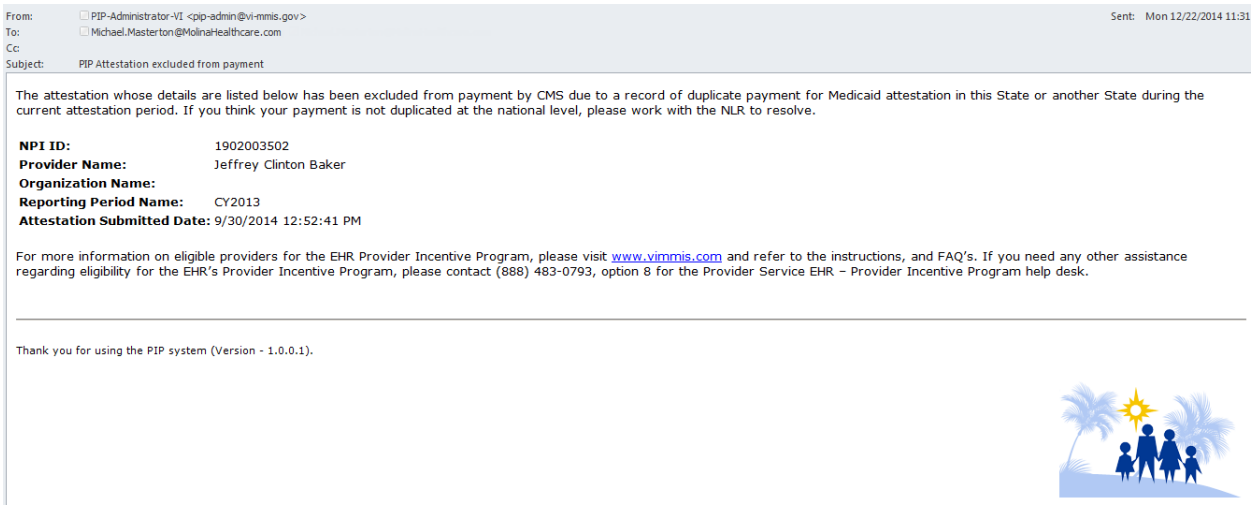
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for rejection: Provider is on a pay hold and not eligible for payment at this time

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

23. Attestation excluded from Payment Email

This email indicates that CMS has already has a payment on record from this provider. Please contact the CMS NLR for questions and concerns.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:31
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation excluded from payment

The attestation whose details are listed below has been excluded from payment by CMS due to a record of duplicate payment for Medicaid attestation in this State or another State during the current attestation period. If you think your payment is not duplicated at the national level, please work with the NLR to resolve.

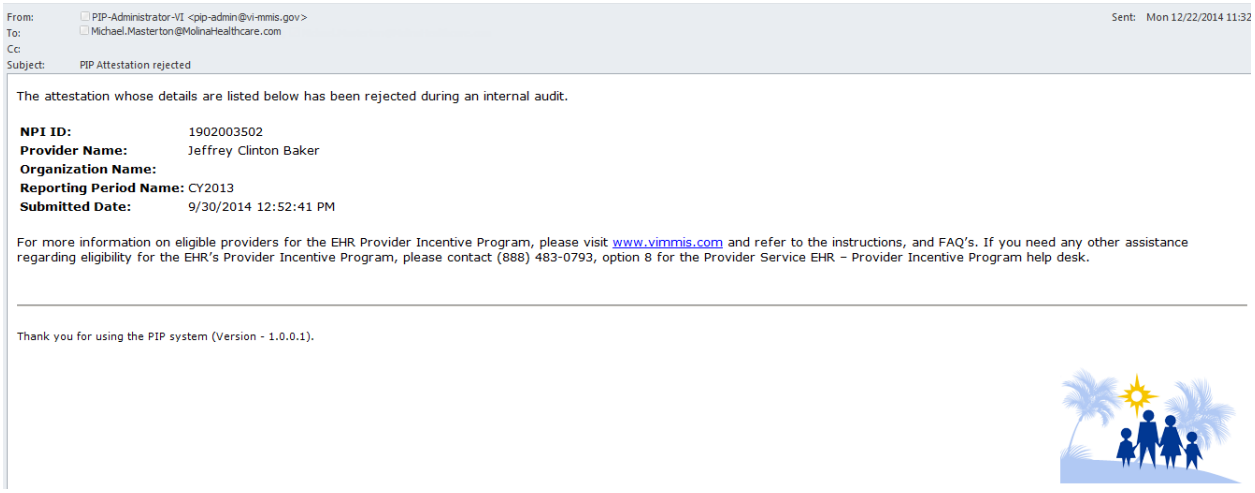
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Attestation Submitted Date: 9/30/2014 12:52:41 PM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

24. Attestation Rejected Email

USVI Medicaid and USVI Medicaid Provider Services staff has the ability to review attestation and reject a submitted attestation. When the attestation is rejected, an email is sent to notify the user of the status change. To find out more information, please contact the Medicaid Provider Services staff at 855-248-7536 option 2.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected
Sent: Mon 12/22/2014 11:32

The attestation whose details are listed below has been rejected during an internal audit.

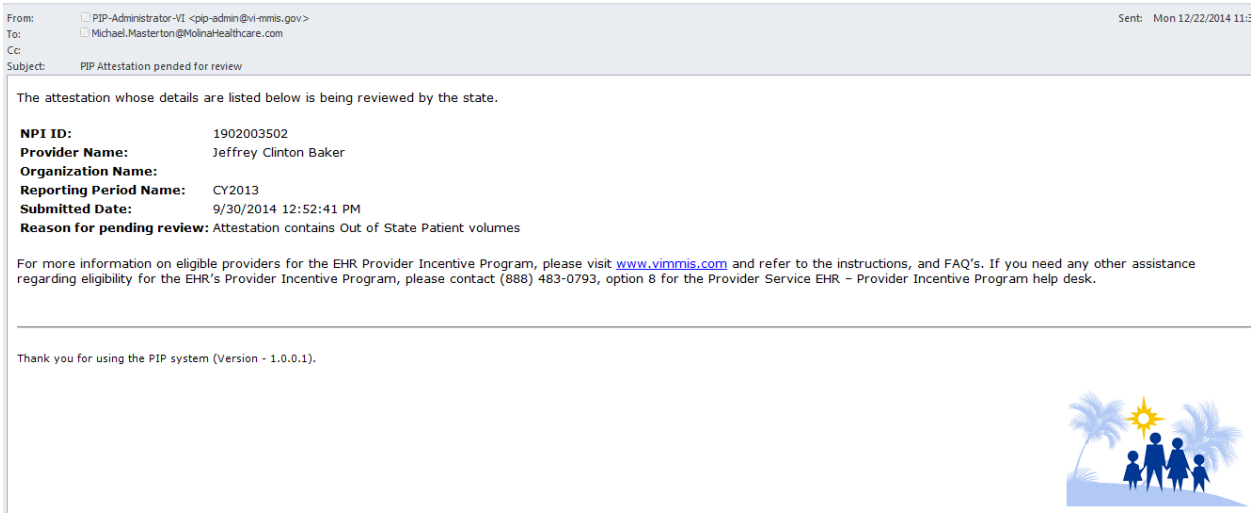
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

25. Attestation Pended for Out of State Entries

If a submitted attestation has passed volume checks and has out of state entries, the attestation will be pended. The USVI Medicaid and USVI Medicaid Provider Services staff will review the required documentation and determine if the attestation is acceptable or not. The following email indicates that the attestation was pended. To find out more information, please contact the Medicaid Provider Services staff at 855-248-7536 option 2.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation pended for review
Sent: Mon 12/22/2014 11:

The attestation whose details are listed below is being reviewed by the state.

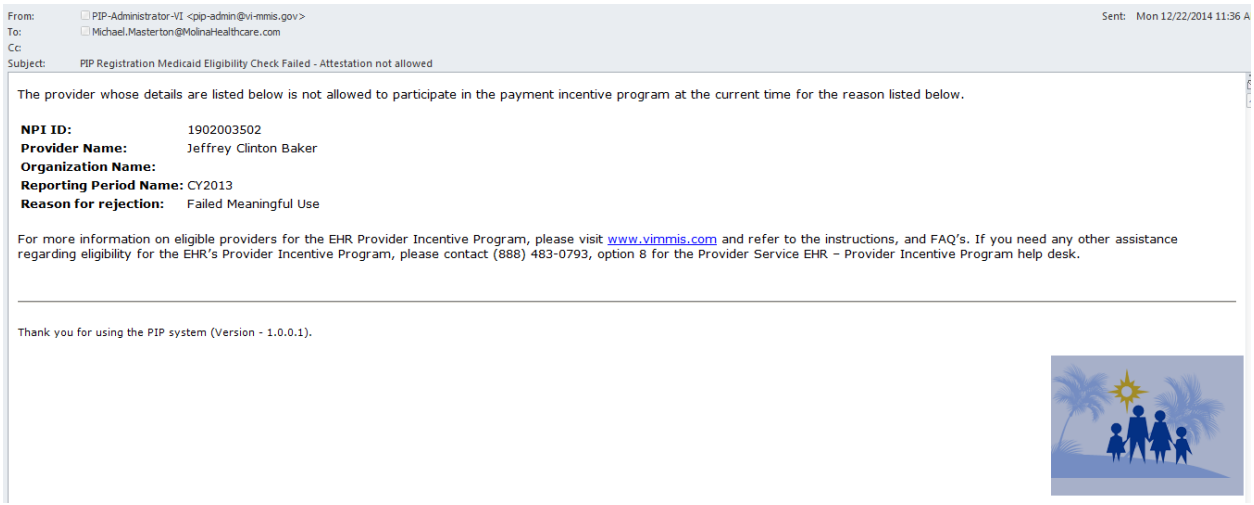
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for pending review: Attestation contains Out of State Patient volumes

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

26. Attestation Failed Meaningful Use

If a submitted attestation did not pass the meaningful use questions, the email is sent to inform the EH.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:36 A
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.

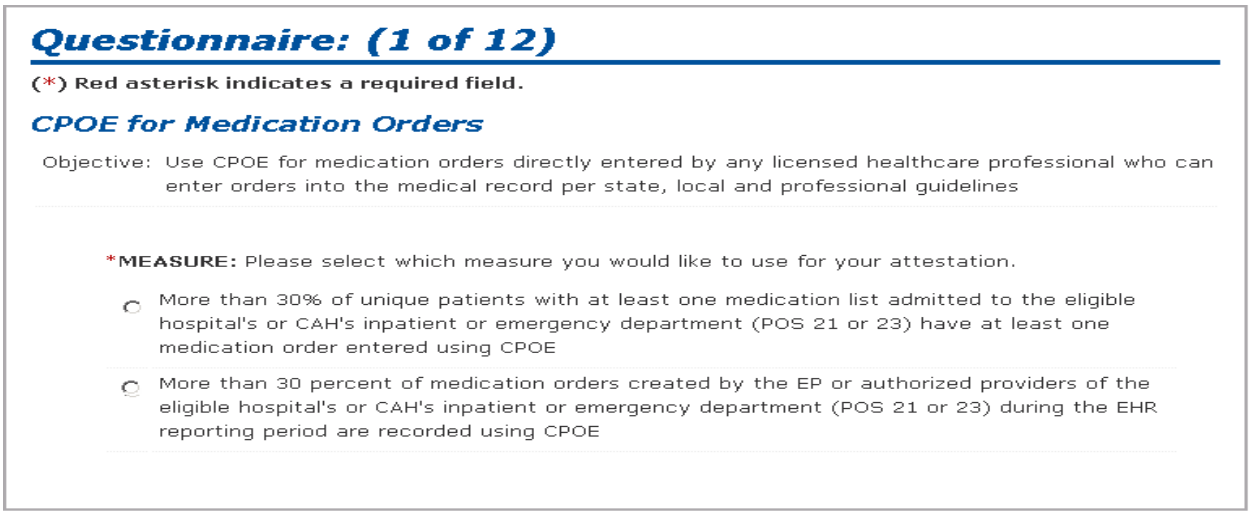
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Reason for rejection: Failed Meaningful Use

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

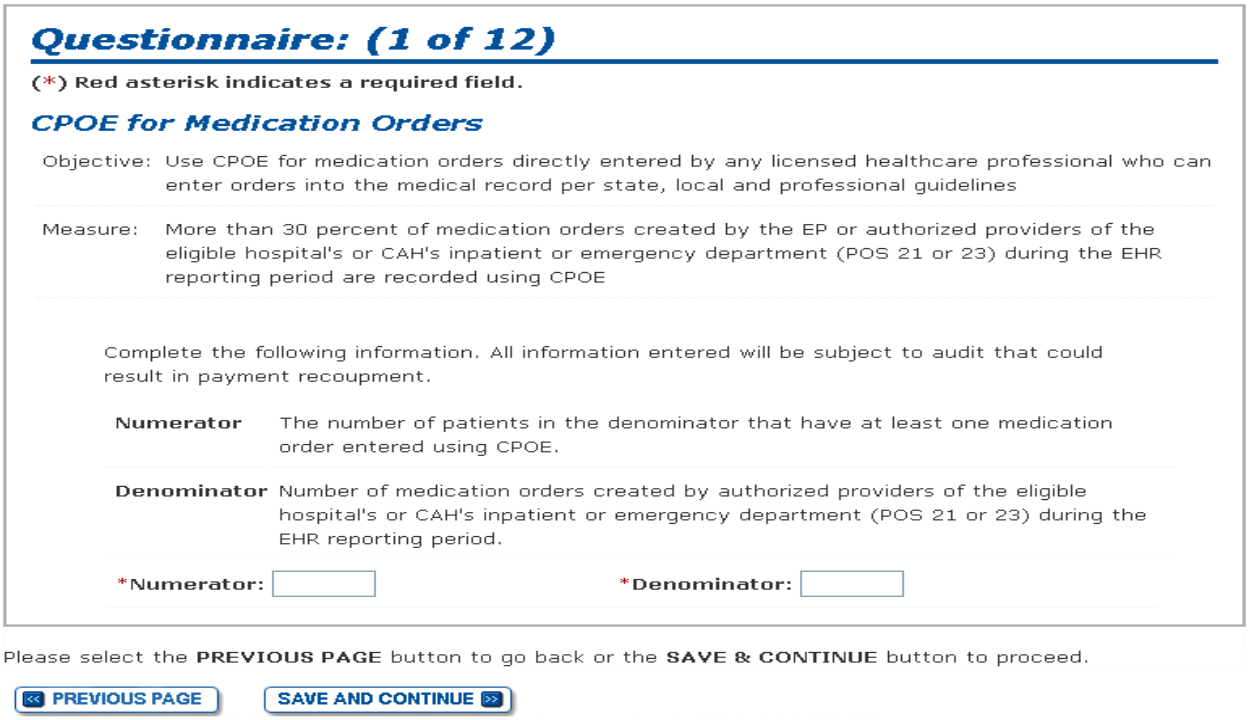
Thank you for using the PIP system (Version - 1.0.0.1).

27. 2013 Meaningful Use Core Measures Screen Shots

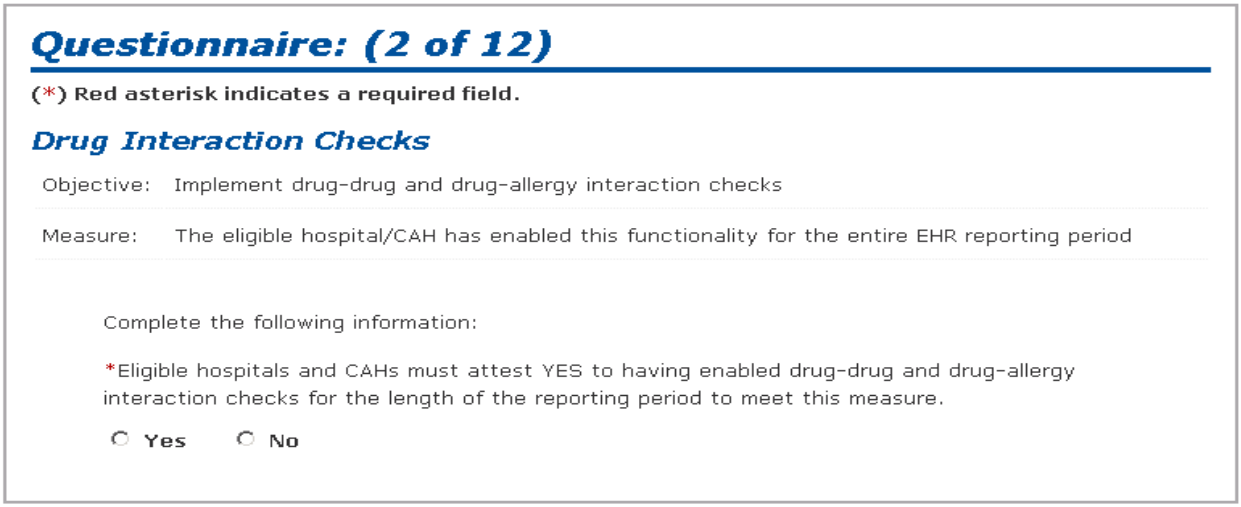
CMS requires that all questions have responses.



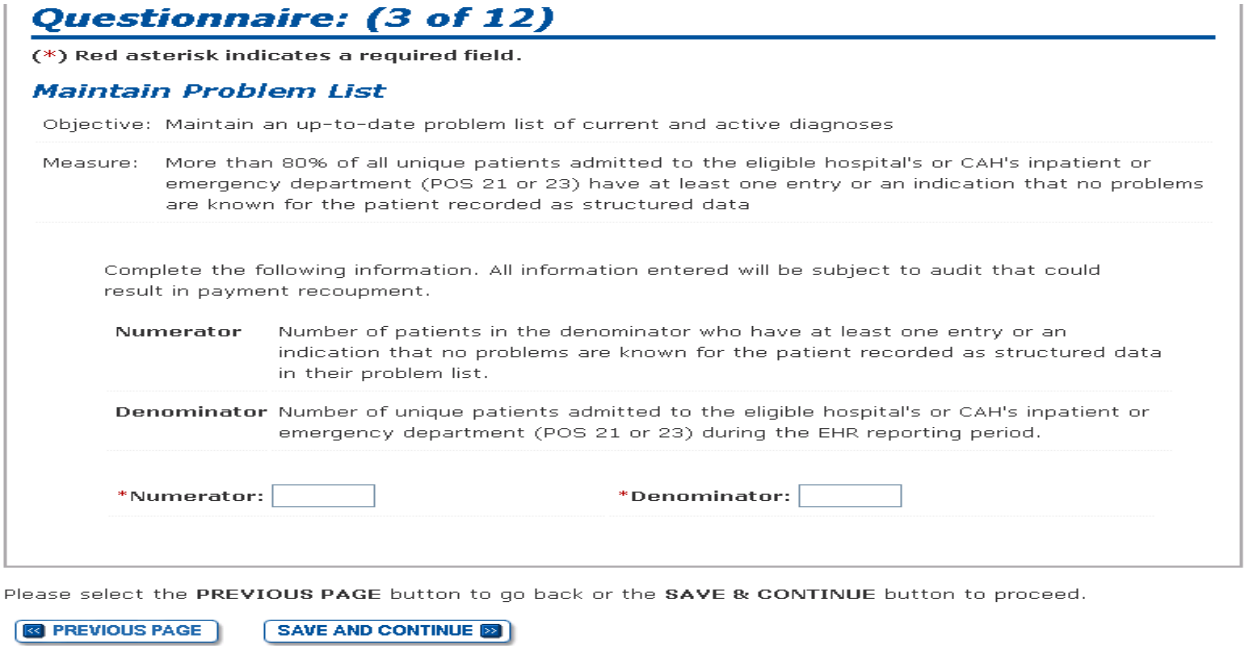
2013 Meaningful Use Core Question 1 – CPOE for Medication Orders



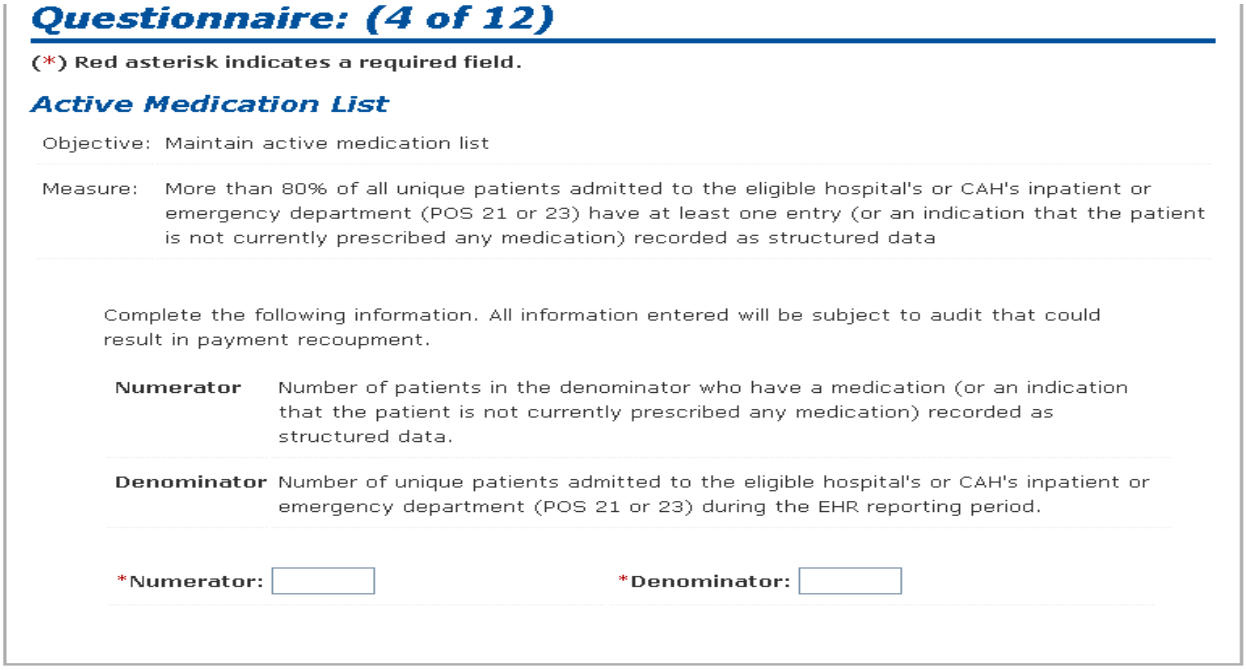
2013 Meaningful Use Core Question 1 – CPOE for Medication Orders Numerator and Denominator entry



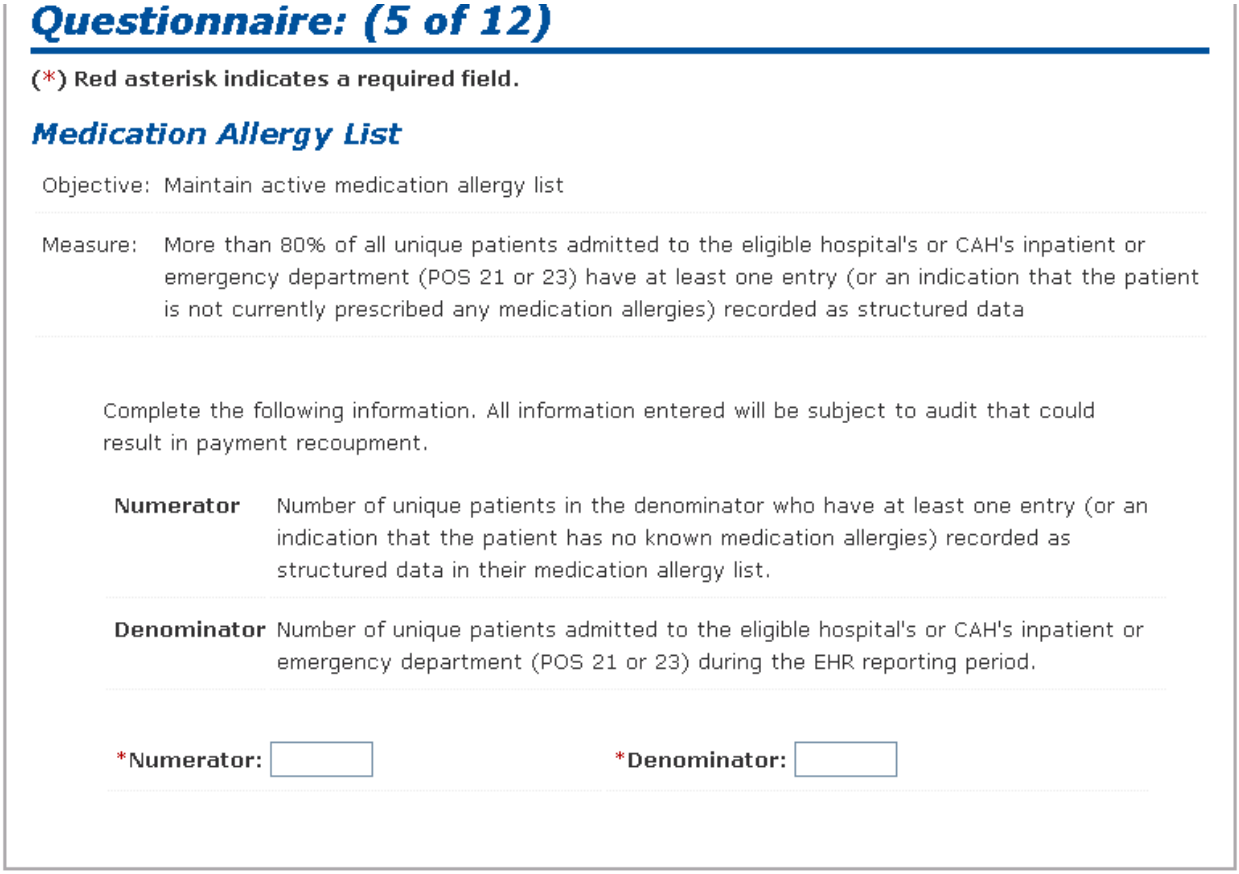
2013 Meaningful Use Core Question 2 – Drug Interaction Checks



2013 Meaningful Use Core Question 3 – Maintain Problem List



2013 Meaningful Use Core Question 4 – Active Medication List



Questionnaire: (5 of 12)

(*) Red asterisk indicates a required field.

Medication Allergy List

Objective:	Maintain active medication allergy list
Measure:	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication allergies) recorded as structured data

Complete the following information. All information entered will be subject to audit that could result in payment recoupment.

Numerator	Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
Denominator	Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator: *Denominator:

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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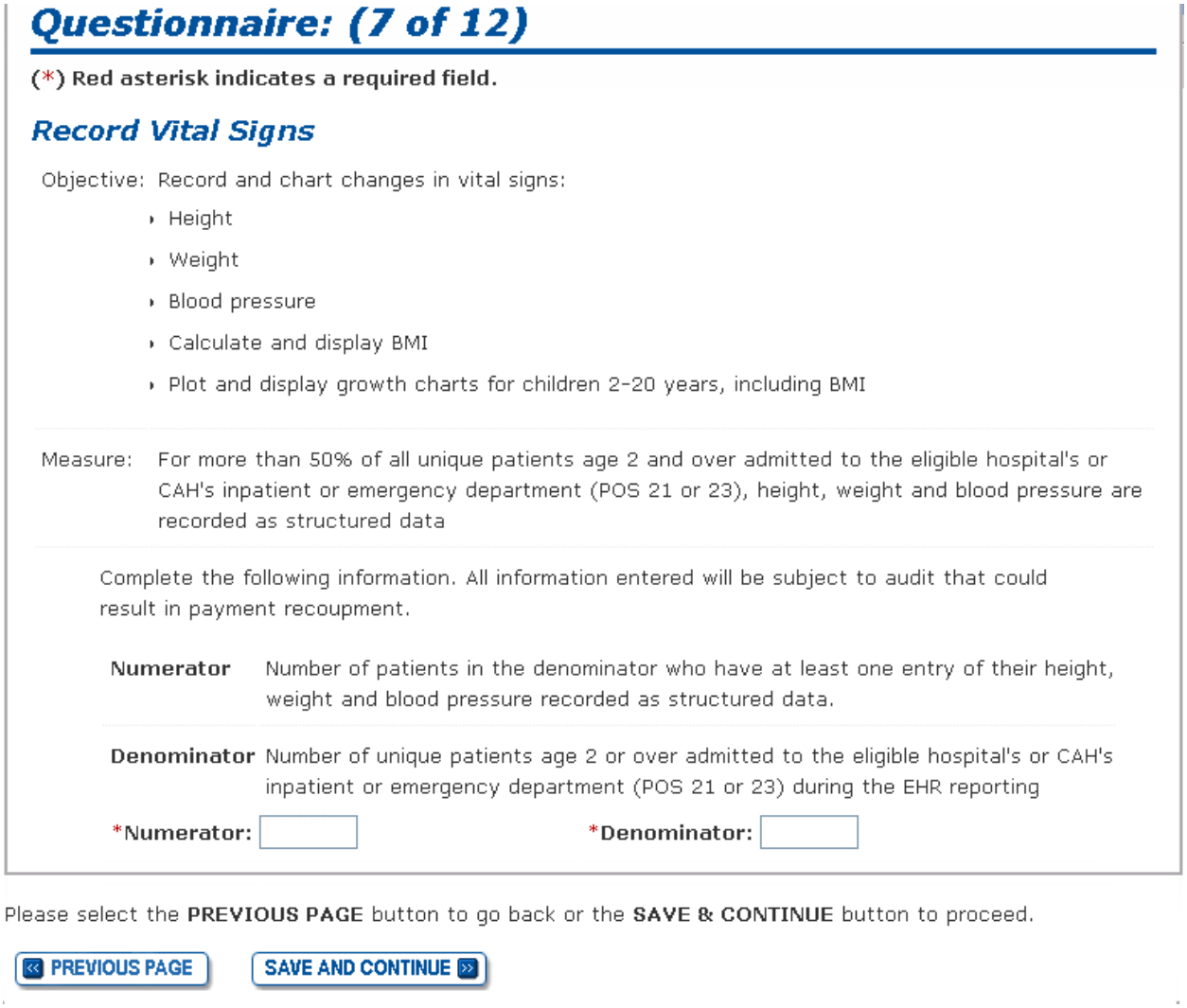
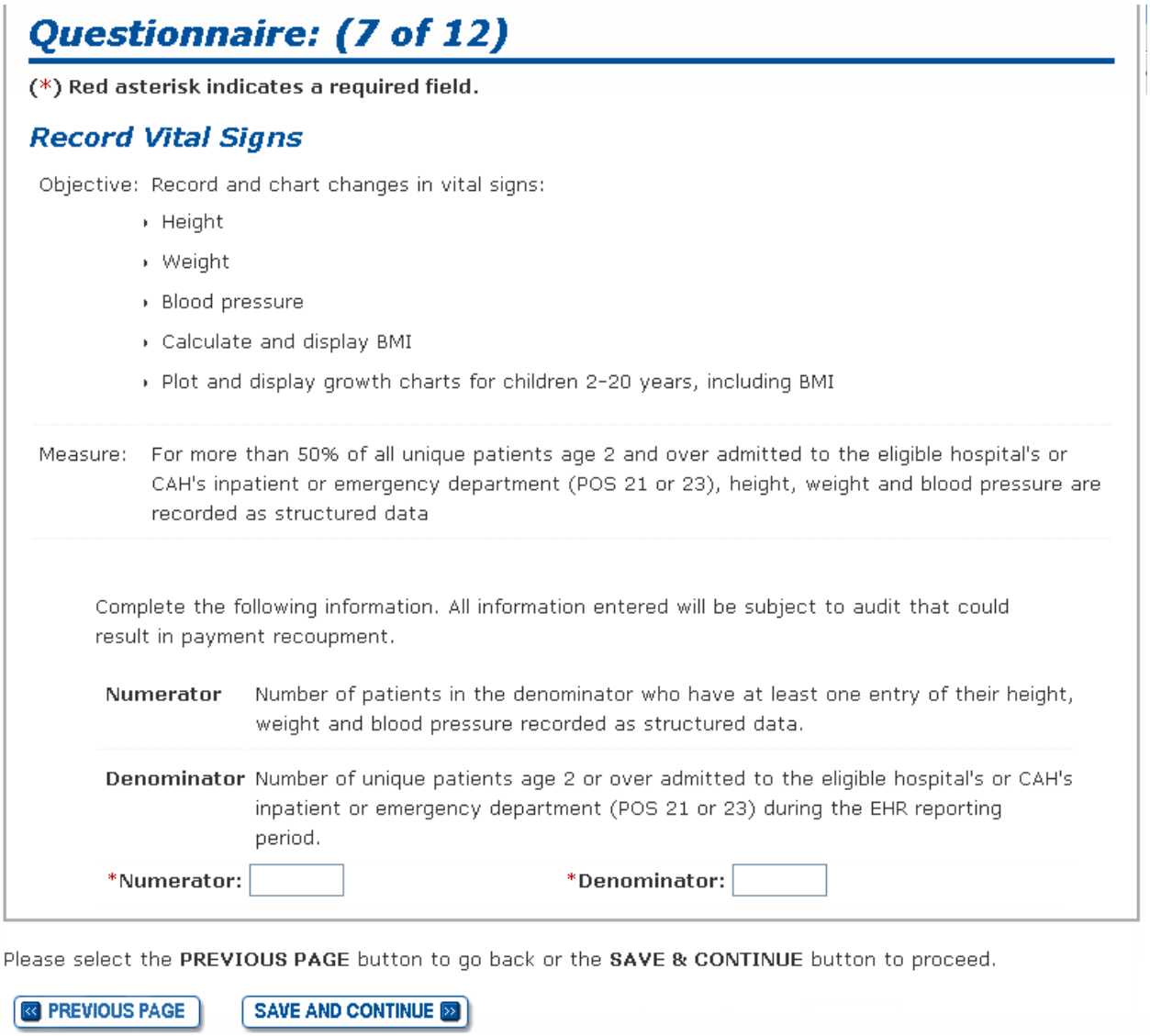
2013 Meaningful Use Core Question 5 – Medication Allergy List



2013 Meaningful Use Core Question 6 – Record Demographics



Questionnaire: (7 of 12)

(*) Red asterisk indicates a required field.

Record Vital Signs

Objective: Record and chart changes in vital signs:

- Height
- Weight
- Blood pressure
- Calculate and display BMI
- Plot and display growth charts for children 2-20 years, including BMI

Measure: For more than 50% of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data

Complete the following information. All information entered will be subject to audit that could result in payment recoupment.

Numerator	Number of patients in the denominator who have at least one entry of their height, weight and blood pressure recorded as structured data.
Denominator	Number of unique patients age 2 or over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator: *Denominator:

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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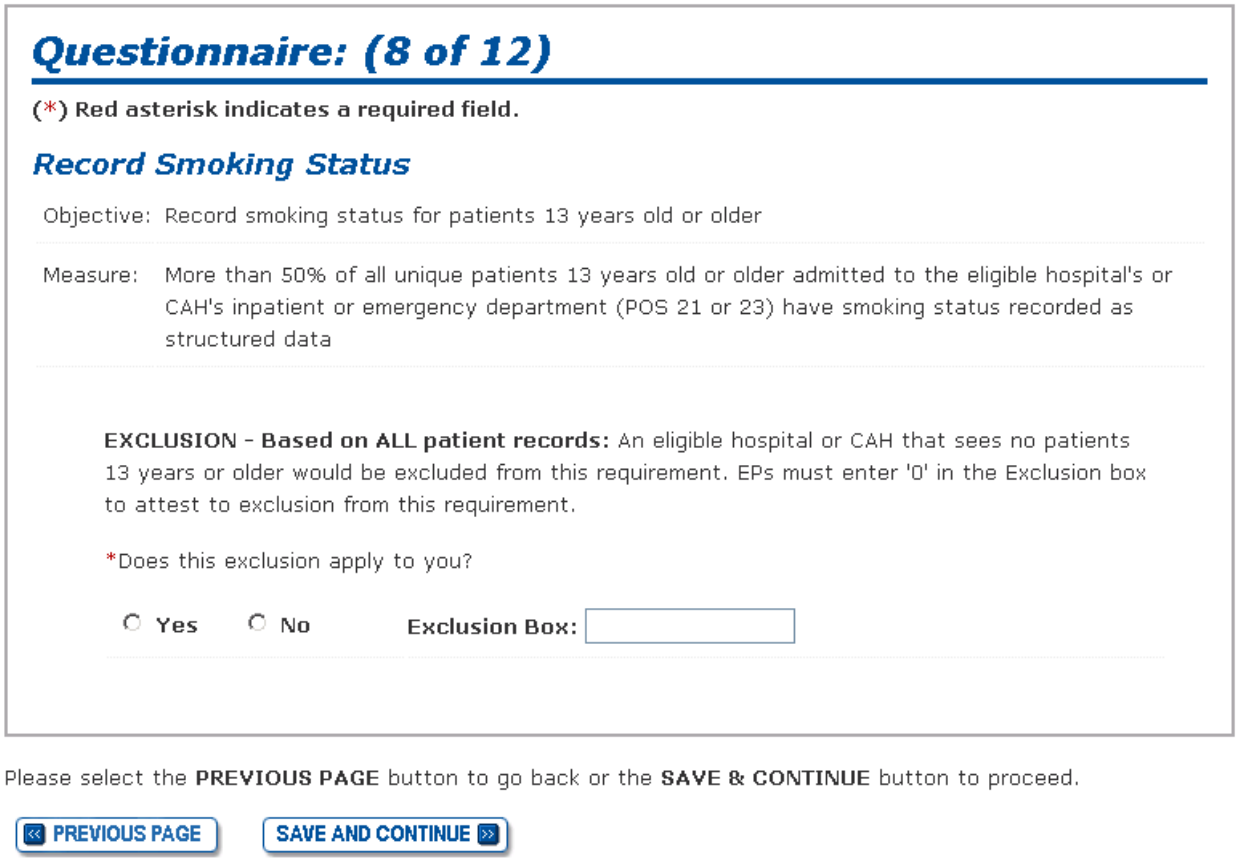
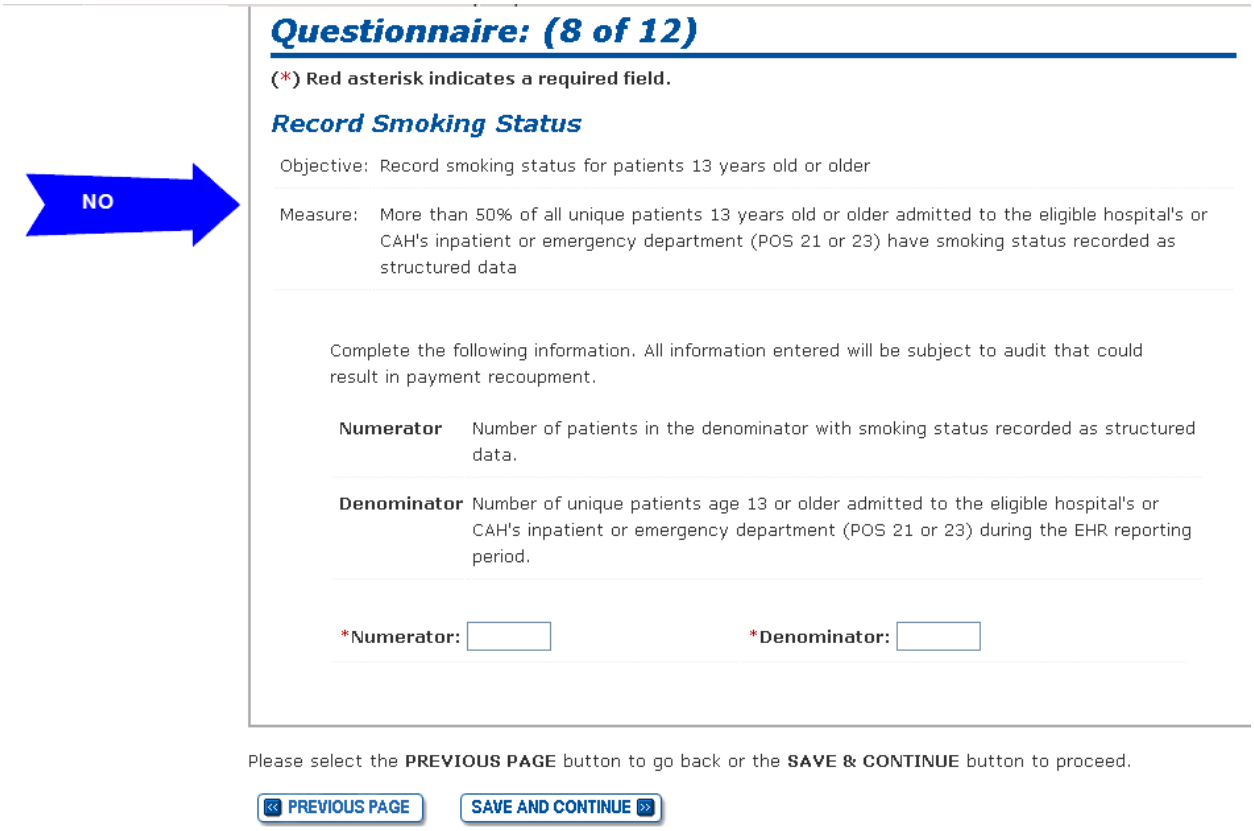
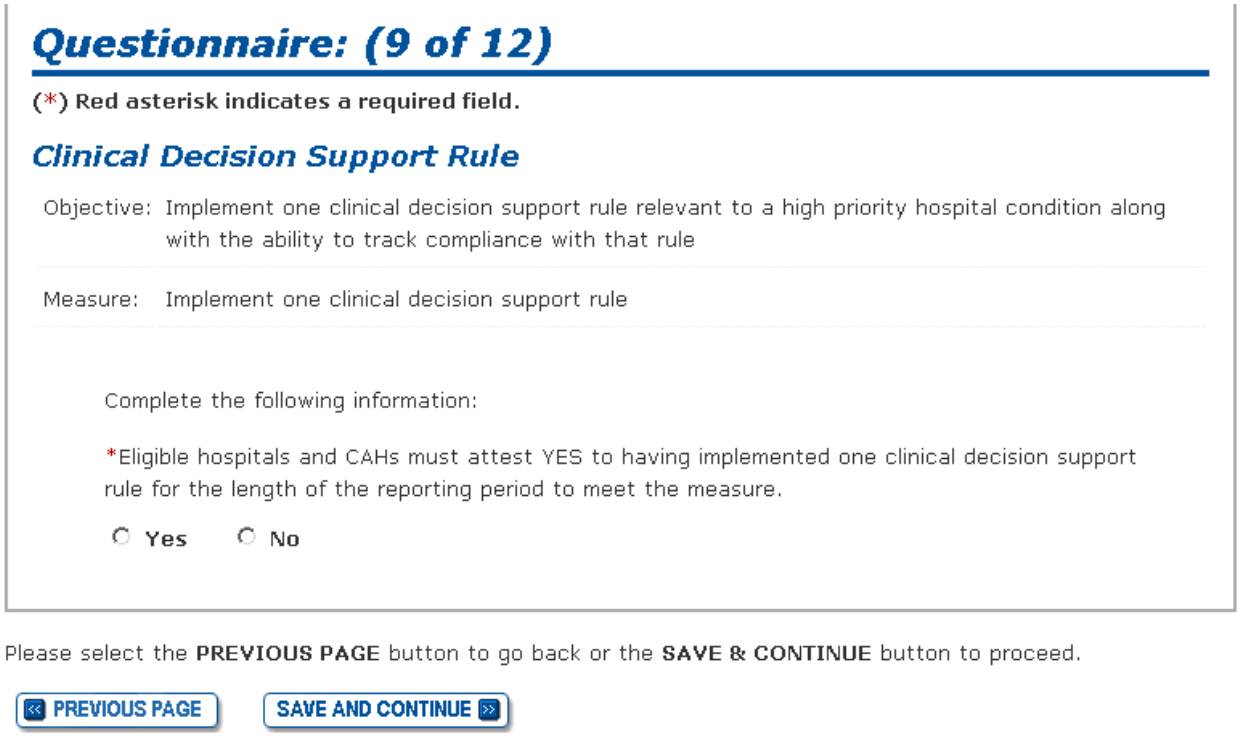
2013 Meaningful Use Core Question 7 – Record Vital Signs



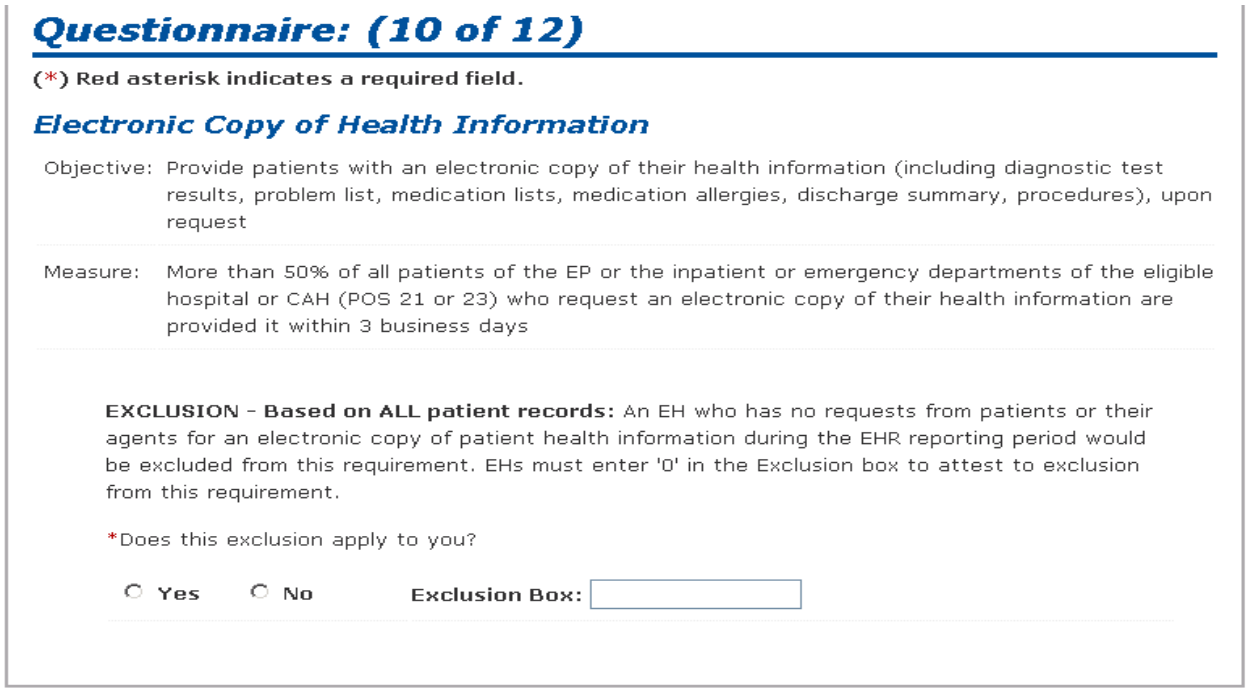
2013 Meaningful Use Core Question 8 – Record Smoking Status



2013 Meaningful Use Core Question 8 – Answer No to Record Smoking Status exclusion



2013 Meaningful Use Core Question 9 – Clinical Decision Support Rule



Questionnaire: (10 of 12)

(*) Red asterisk indicates a required field.

Electronic Copy of Health Information

Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request

Measure: More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days

EXCLUSION – Based on ALL patient records: An EH who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. EHs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

*Does this exclusion apply to you?

Yes No **Exclusion Box:**

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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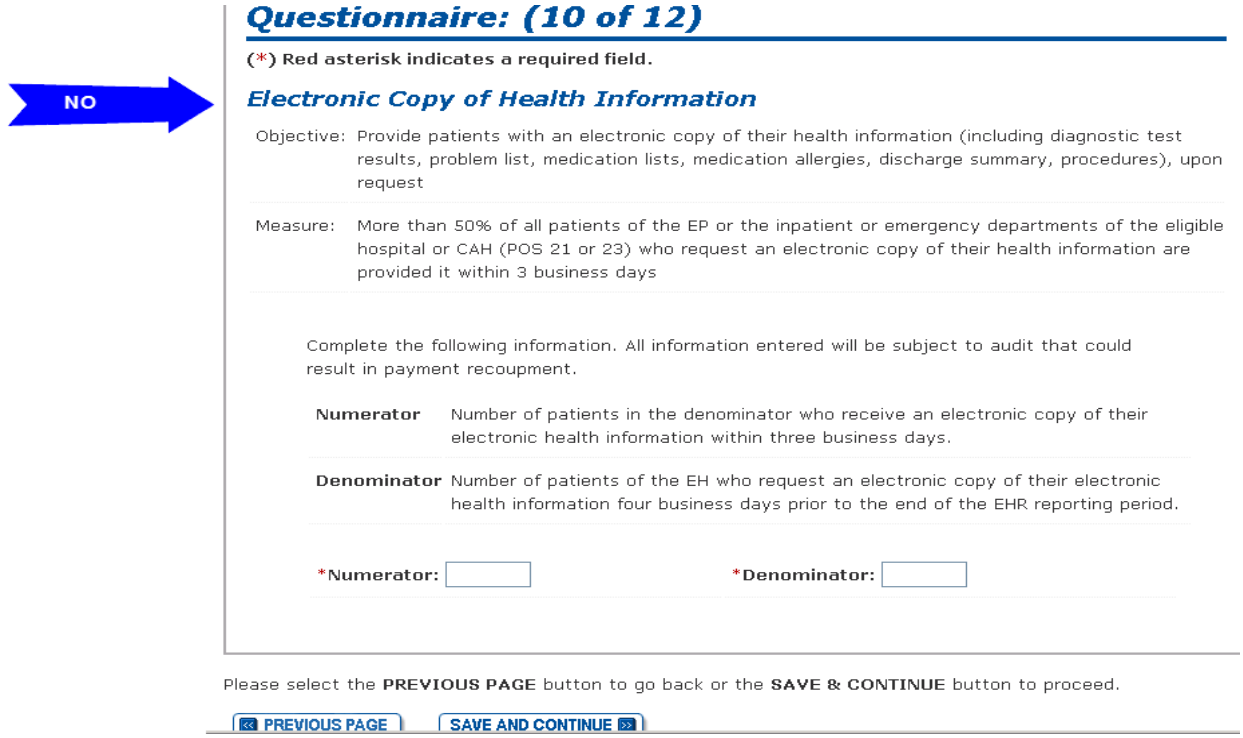
2013 Meaningful Use Core Question 10 – Electronic Copy of Health Information



Questionnaire: (10 of 12)

(*) Red asterisk indicates a required field.

Electronic Copy of Health Information

Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request

Measure: More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days

Complete the following information. All information entered will be subject to audit that could result in payment recoupment.

Numerator Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

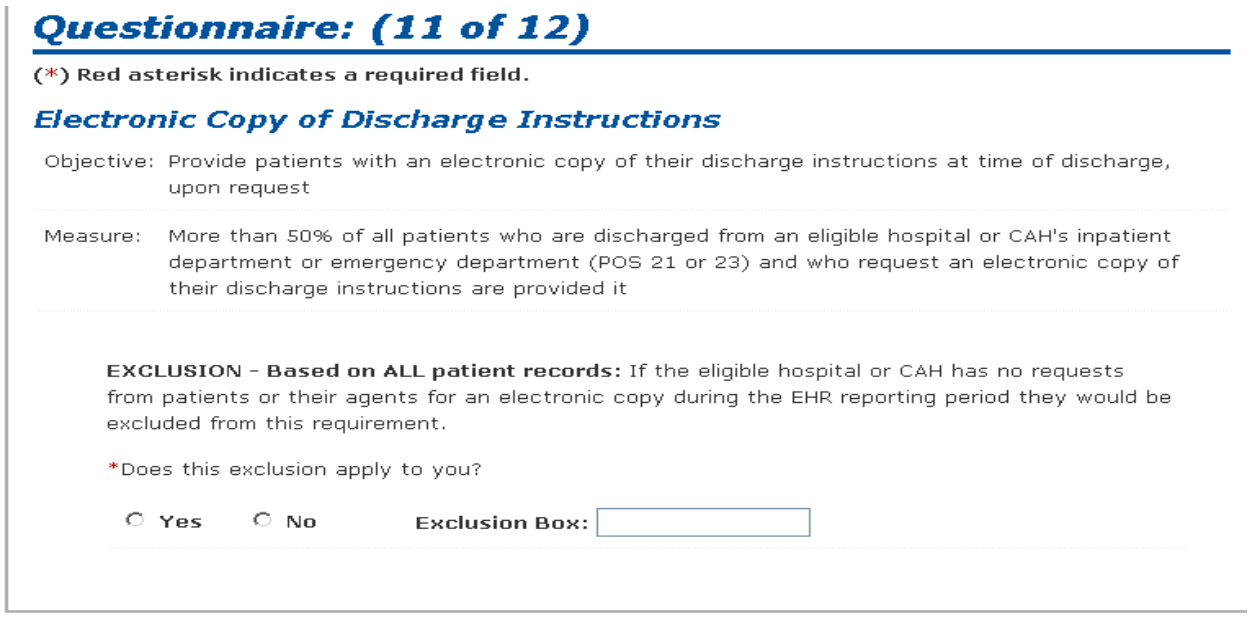
Denominator Number of patients of the EH who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

***Numerator:** ***Denominator:**

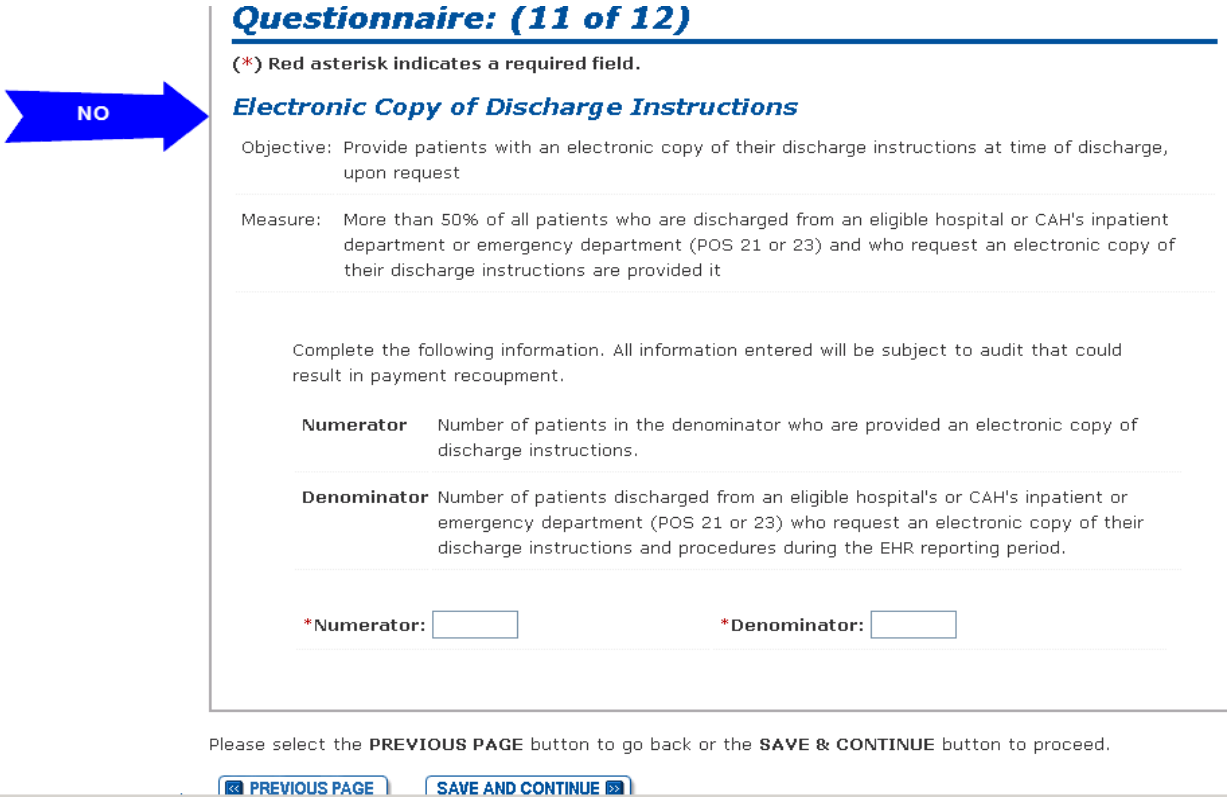
Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

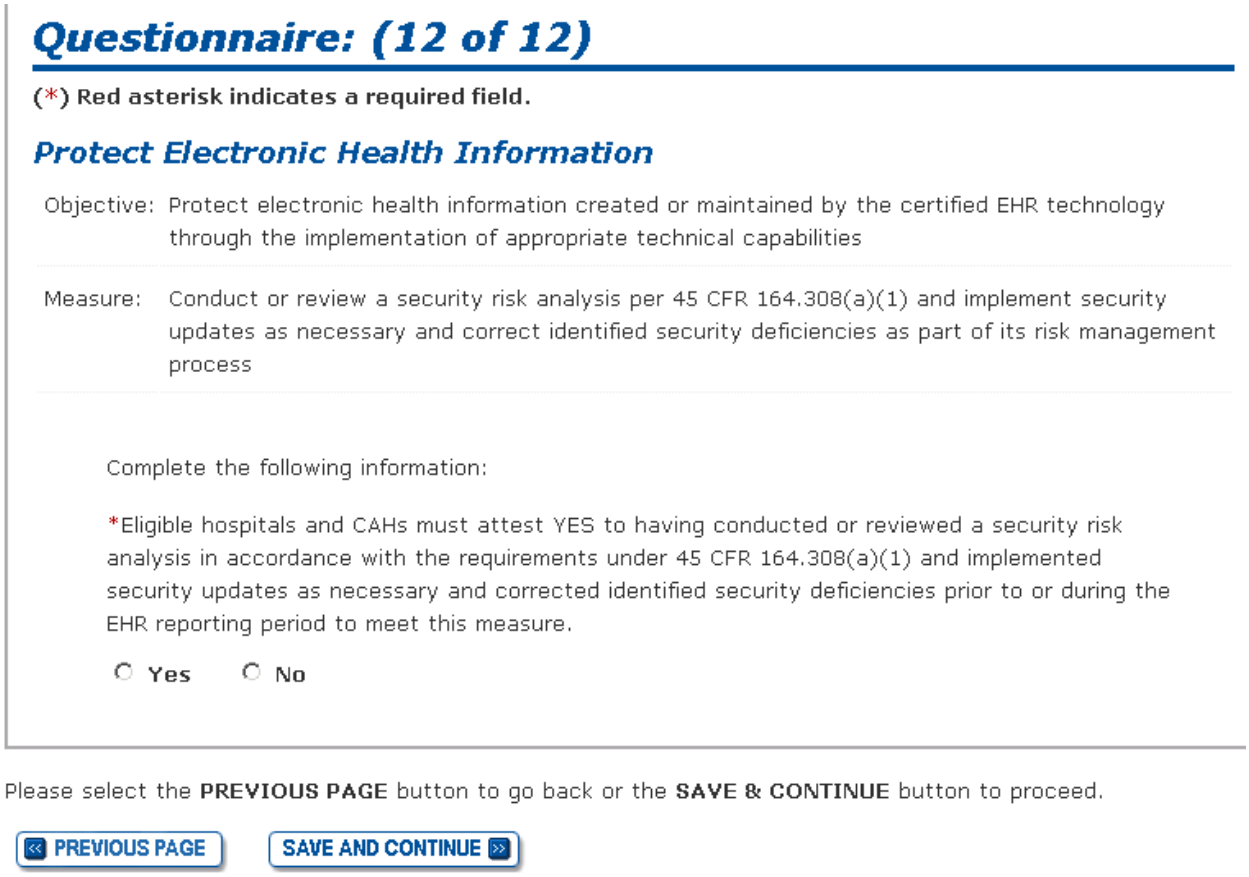
2013 Meaningful Use Core Question 10 – Answered No to Electronic Copy of Health Info. exception



2013 Meaningful Use Core Question 11 – Electronic Copy of Discharge Instructions



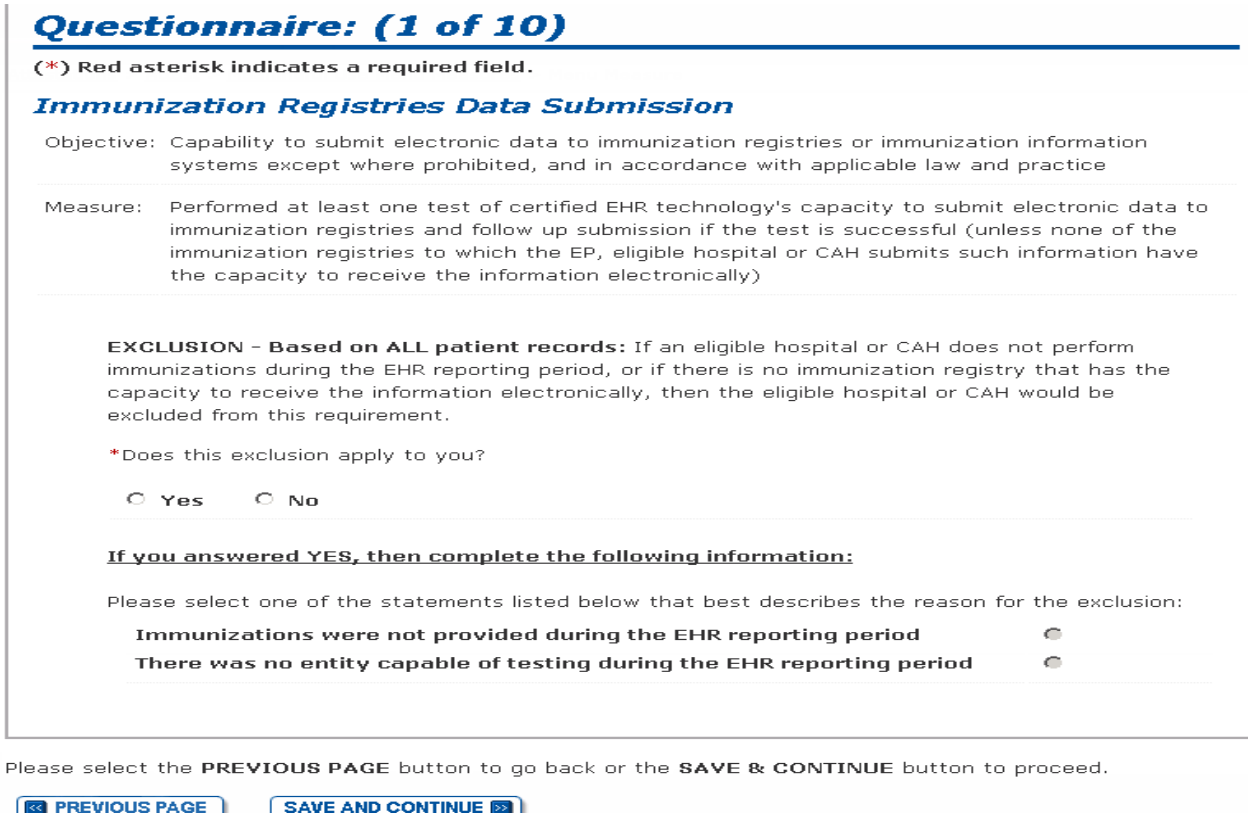
2013 Meaningful Use Core Question 11 – Answered No to Electronic Copy of Discharge Instructions exception



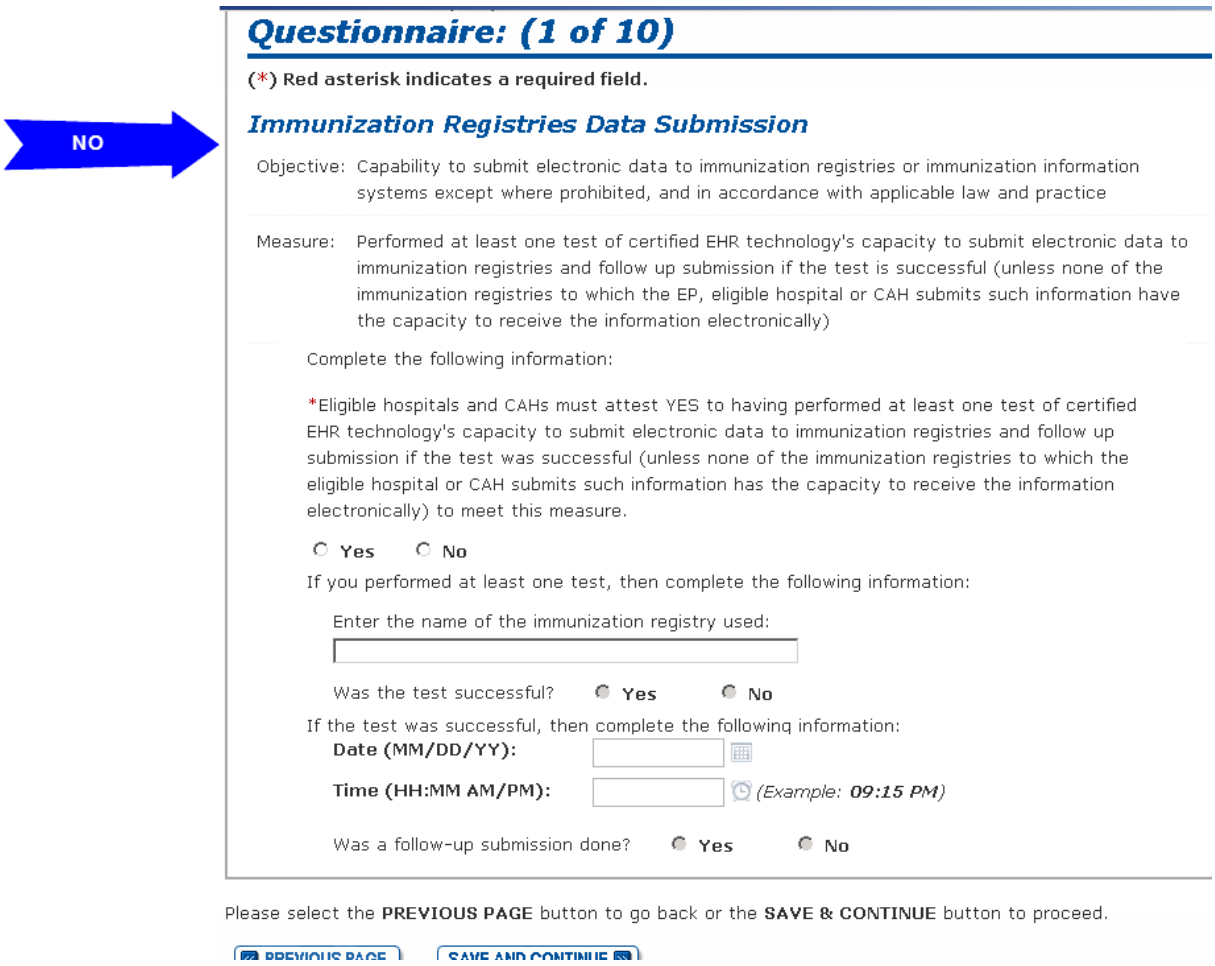
2013 Meaningful Use Core Question 12 – Protect Electronic Health Information

28. 2013 Meaningful Use Menu Measures Questions Screen Shots

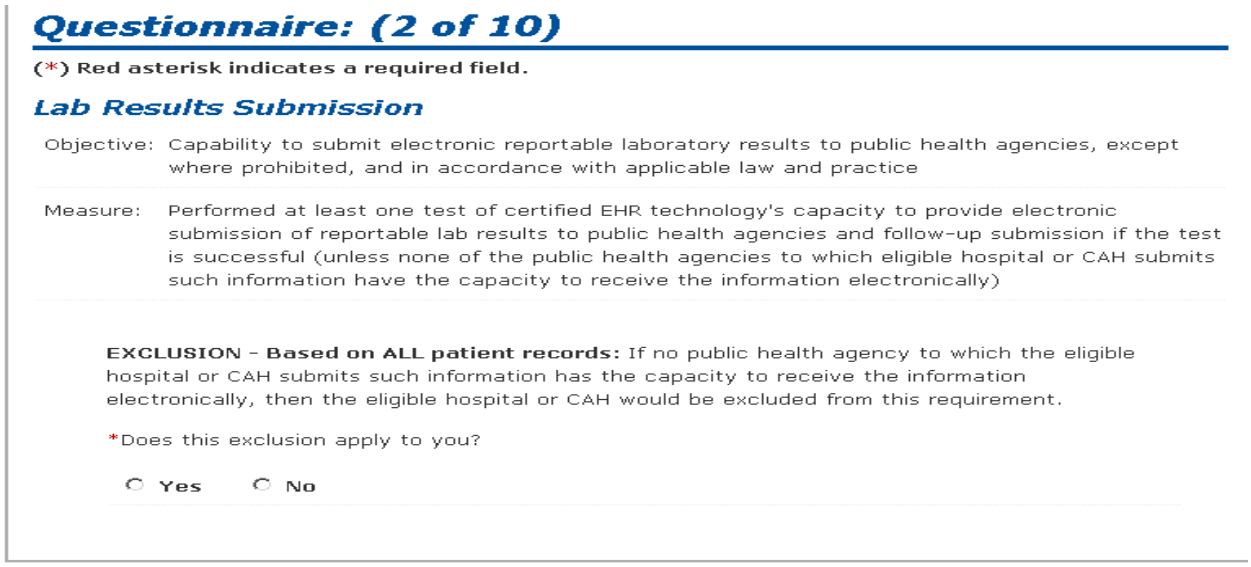
CMS require that a minimum of five questions are selected. One of the five must be a selection of Question 1, 2 or 3, which are public health questions. All questions are displayed for the review.



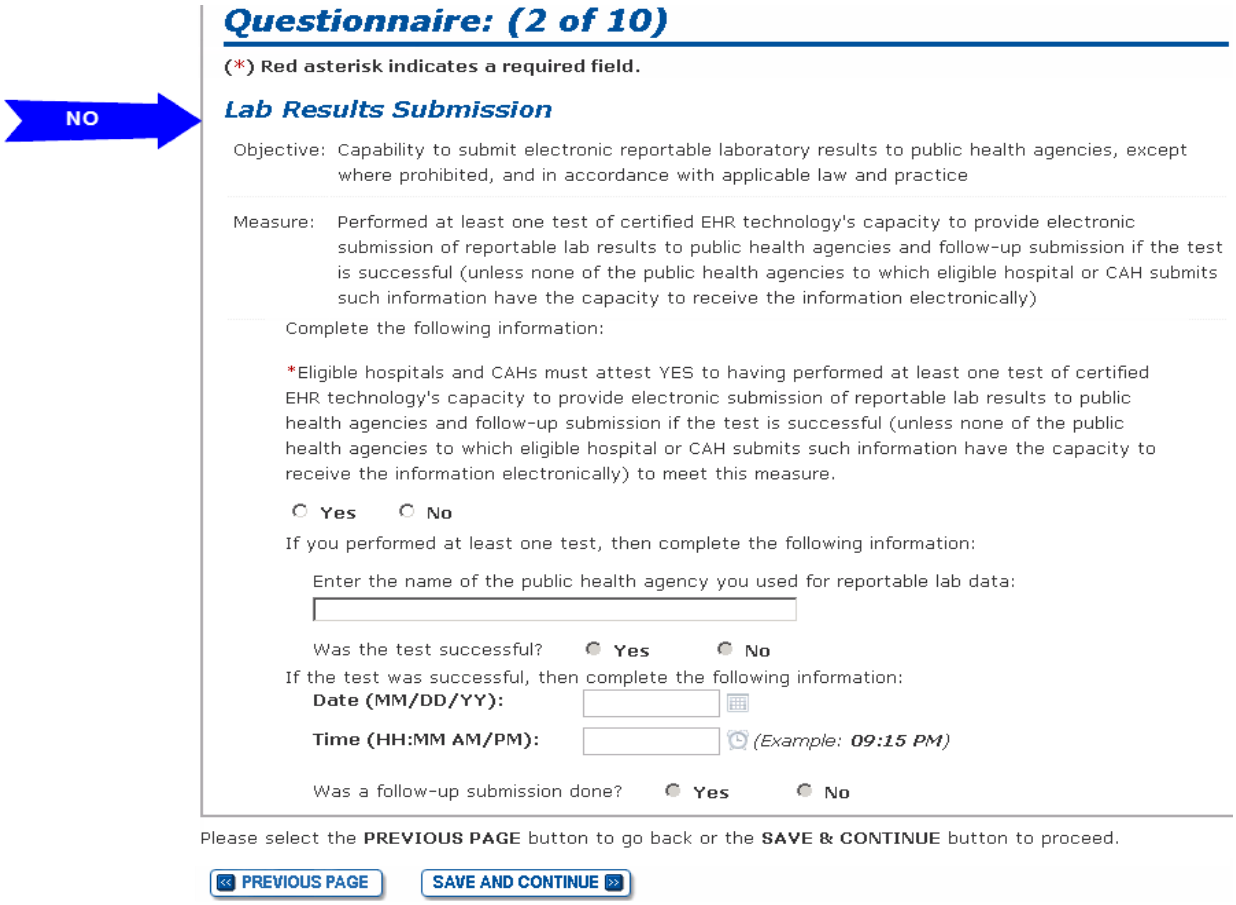
2013 Meaningful Use Menu Measure Question 1 – Immunization Registry



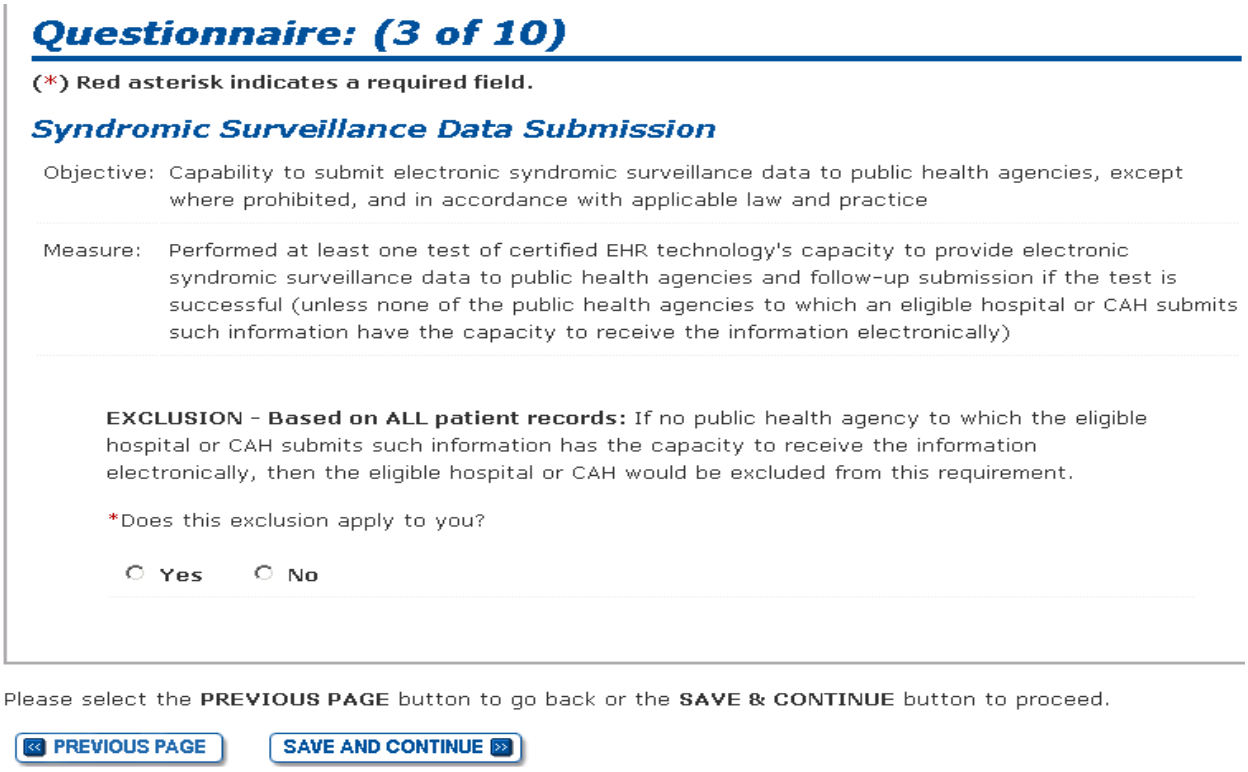
2013 Meaningful Use Menu Measure Question 1 – Answered No to Immunization Registry Exemption



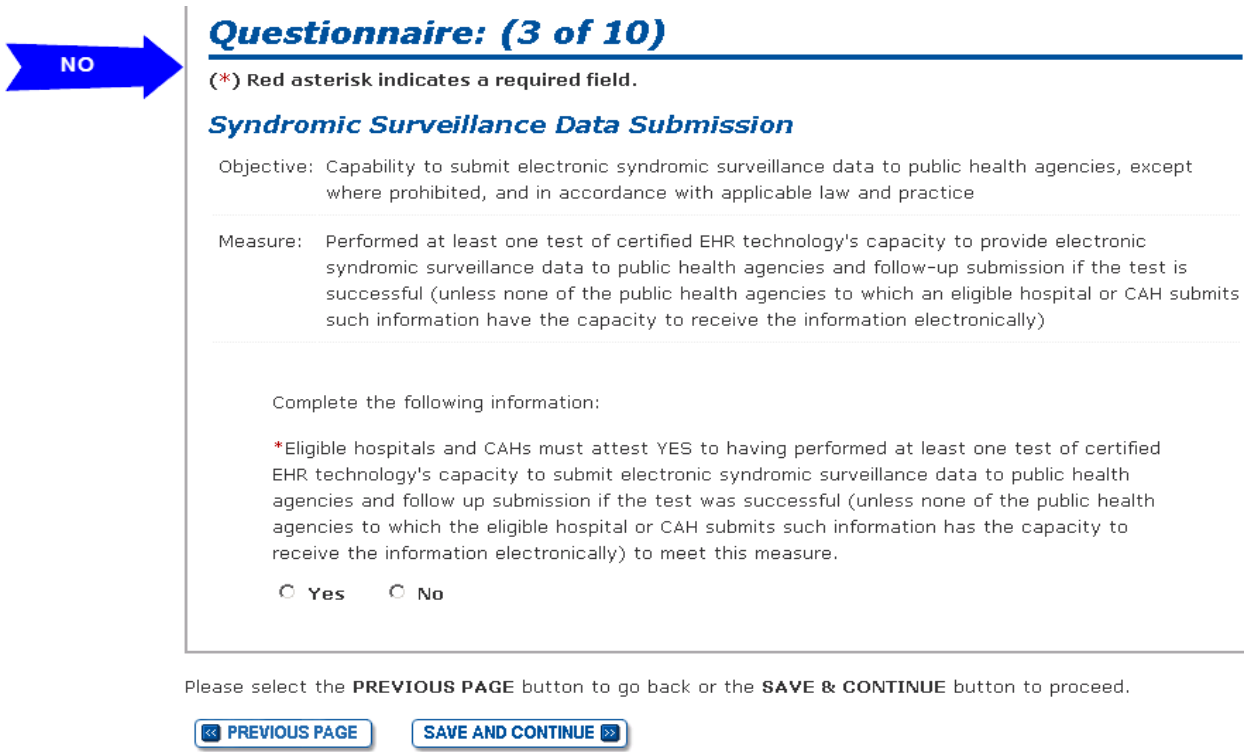
2013 Meaningful Use Menu Measure Question 2 – Lab Results Submission



2013 Meaningful Use Menu Measure Question 2 – Lab Results Submission exclusion do not apply



2013 Meaningful Use Menu Measure Question 3 – Syndromic Surveillance Data Submission



2013 Meaningful Use Menu Measure Question 3 – Syndromic Surveillance Data Submission exclusion do not apply

Questionnaire: (4 of 10)

(*) Red asterisk indicates a required field.

Drug Formulary Checks

Objective:	Implement drug-formulary checks
Measure:	The eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period

Complete the following information:

*Eligible hospitals and CAHs must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure.

○ Yes ○ No

lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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2013 Meaningful Use Menu Measure Question 4 – Drug Formulary Checks

Questionnaire: (5 of 10)

(*) Red asterisk indicates a required field.

Record Advanced Directives

Objective:	Record advance directives for patients 65 years old or older
Measure:	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21 or 23) have an indication of an advance directive status recorded

Complete the following information:

Numerator	The number of patients in the denominator with an indication of an advanced directive entered using structured data.
Denominator	Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.

*Numerator: *Denominator:

lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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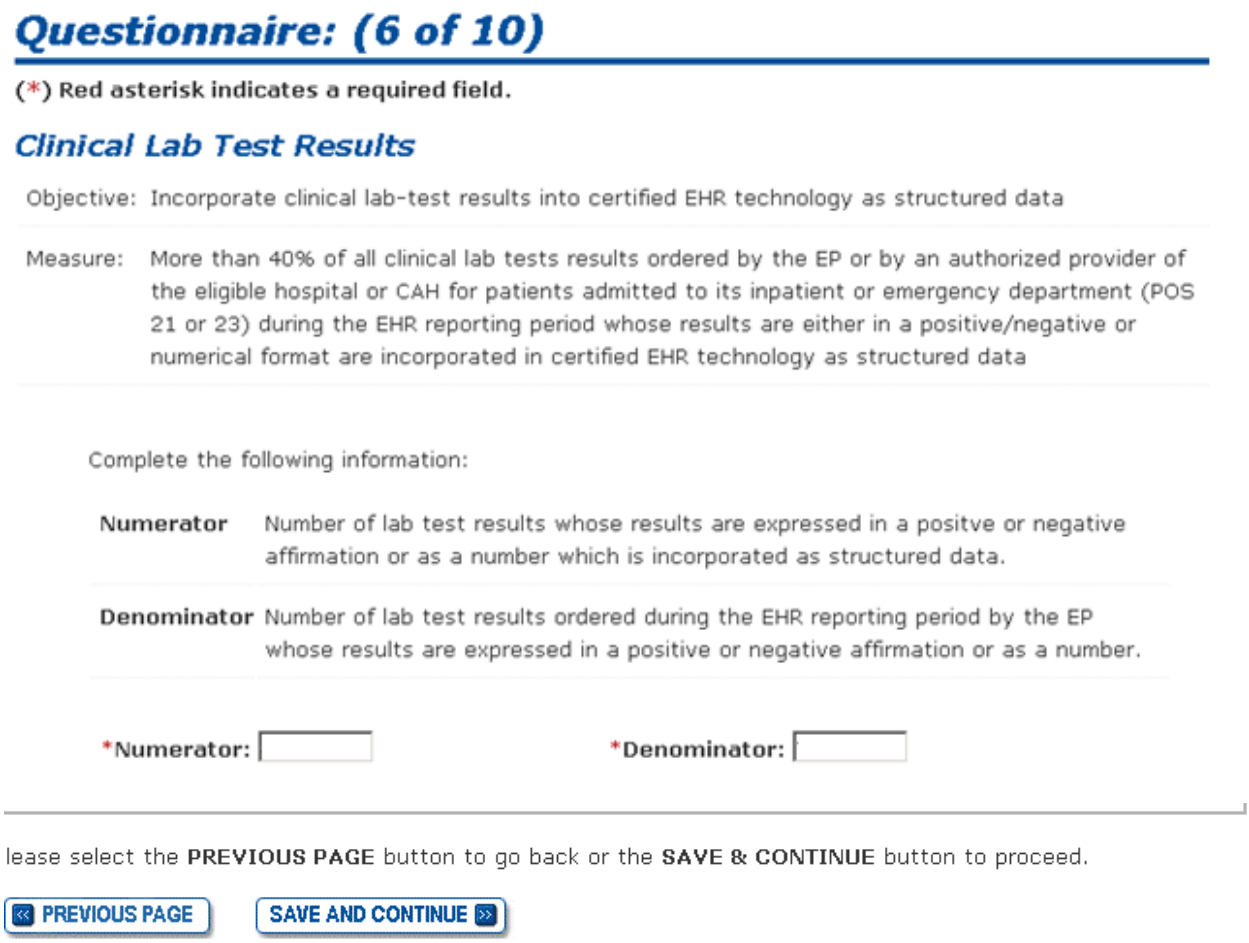
2013 Meaningful Use Menu Measure Question 5 -- Record Advanced Directives



Questionnaire: (6 of 10)

(*) Red asterisk indicates a required field.

Clinical Lab Test Results

Objective:	Incorporate clinical lab-test results into certified EHR technology as structured data
Measure:	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data

Complete the following information:

Numerator	Number of lab test results whose results are expressed in a positve or negative affirmation or as a number which is incorporated as structured data.
Denominator	Number of lab test results ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.

*Numerator: *Denominator:

lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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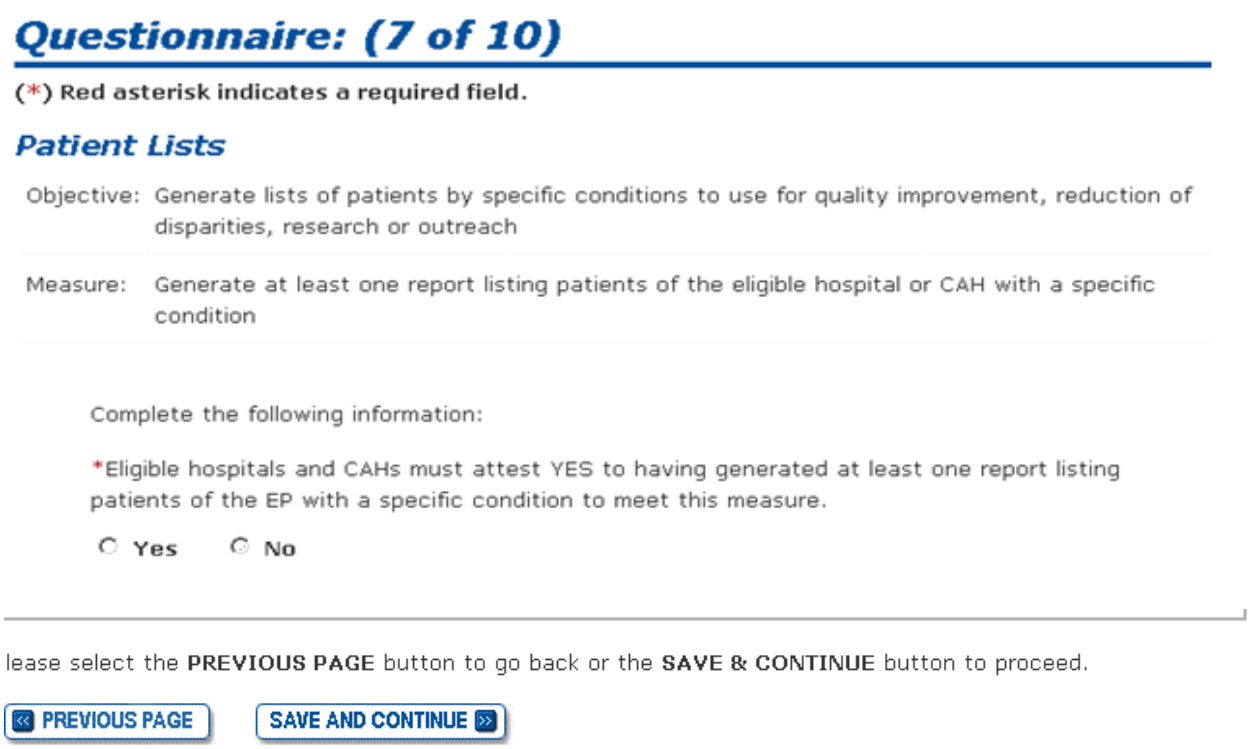
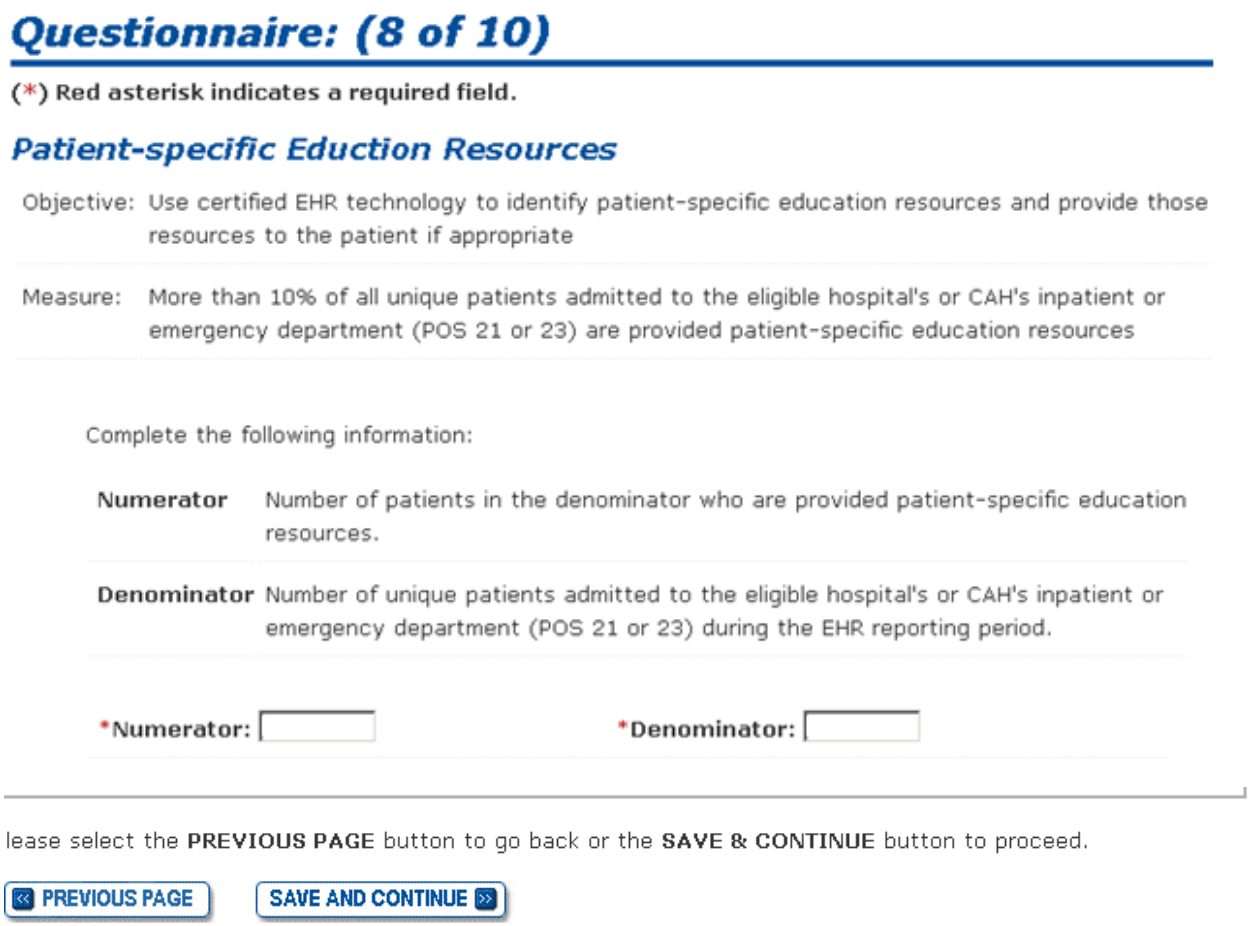
2013 Meaningful Use Menu Measure Question 6 – Clinical Lab Test Results



2013 Meaningful Use Menu Measure Question 7 – Patient Lists



Questionnaire: (8 of 10)

(*) Red asterisk indicates a required field.

Patient-specific Eduction Resources

Objective:	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
Measure:	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources

Complete the following information:

Numerator	Number of patients in the denominator who are provided patient-specific education resources.
Denominator	Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator: *Denominator:

lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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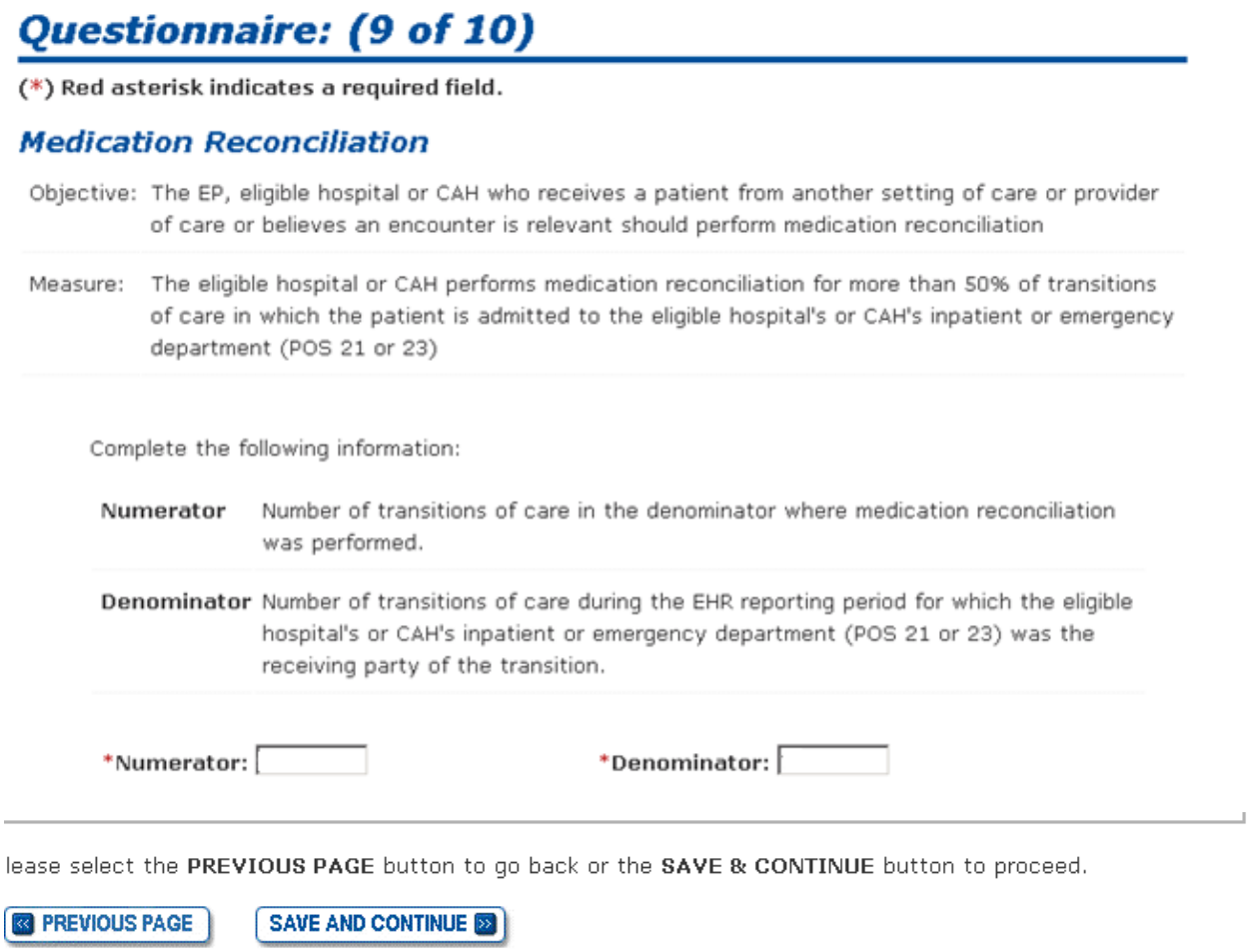
2013 Meaningful Use Menu Measure Question 8 – Patient-specific Education Resources



Questionnaire: (9 of 10)

(*) Red asterisk indicates a required field.

Medication Reconciliation

Objective:	The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation
Measure:	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)

Complete the following information:

Numerator	Number of transitions of care in the denominator where medication reconciliation was performed.
Denominator	Number of transitions of care during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.

*Numerator: *Denominator:

lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

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2013 Meaningful Use Menu Measure Question 9 – Medication Reconciliation

Questionnaire: (10 of 10)

(*) Red asterisk indicates a required field.

Transition of Care Summary

Objective:	The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral
Measure:	The eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals

Complete the following information:

Numerator	Number of transitions of care and referrals in the denominator where a summary of care record was provided.
Denominator	Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

*Numerator: *Denominator:

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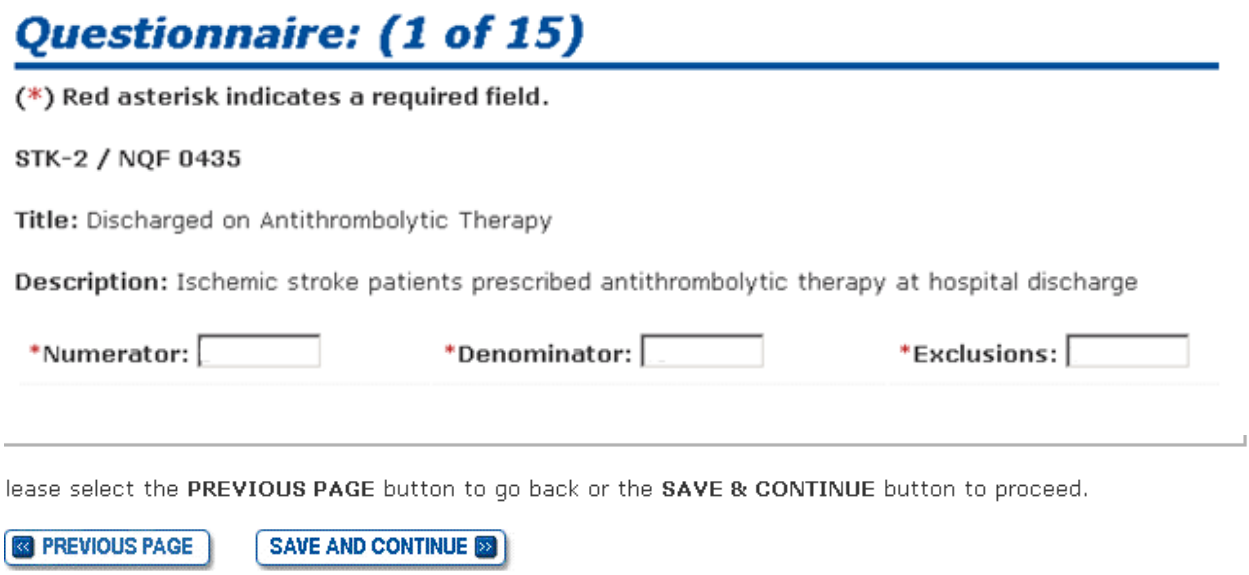
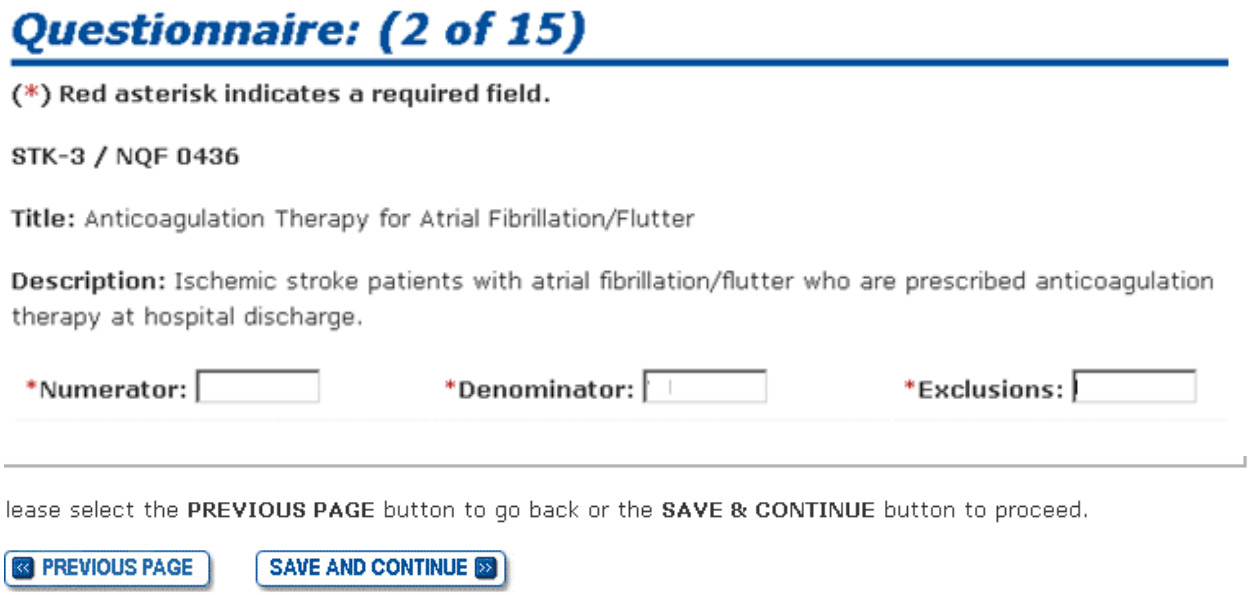
2013 Meaningful Use Menu Measure Question 10 – Transition of Care Summary

29. 201 3 Clinical Quality Measures Questions Screen Shots

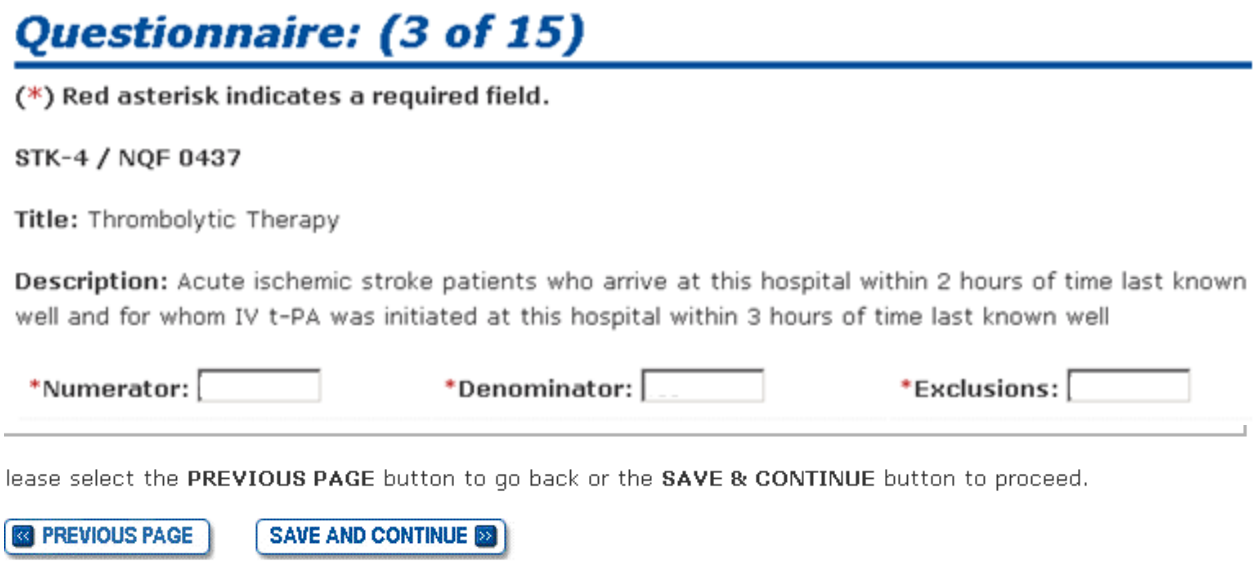
CMS requires that the fifteen questions are responded to. Each question's screen shot is below.



2013 Clinical Quality Measures Question 1



2013 Clinical Quality Measures Question 2



Questionnaire: (3 of 15)

(*) Red asterisk indicates a required field.

STK-4 / NQF 0437

Title: Thrombolytic Therapy

Description: Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well

*Numerator: *Denominator: *Exclusions:

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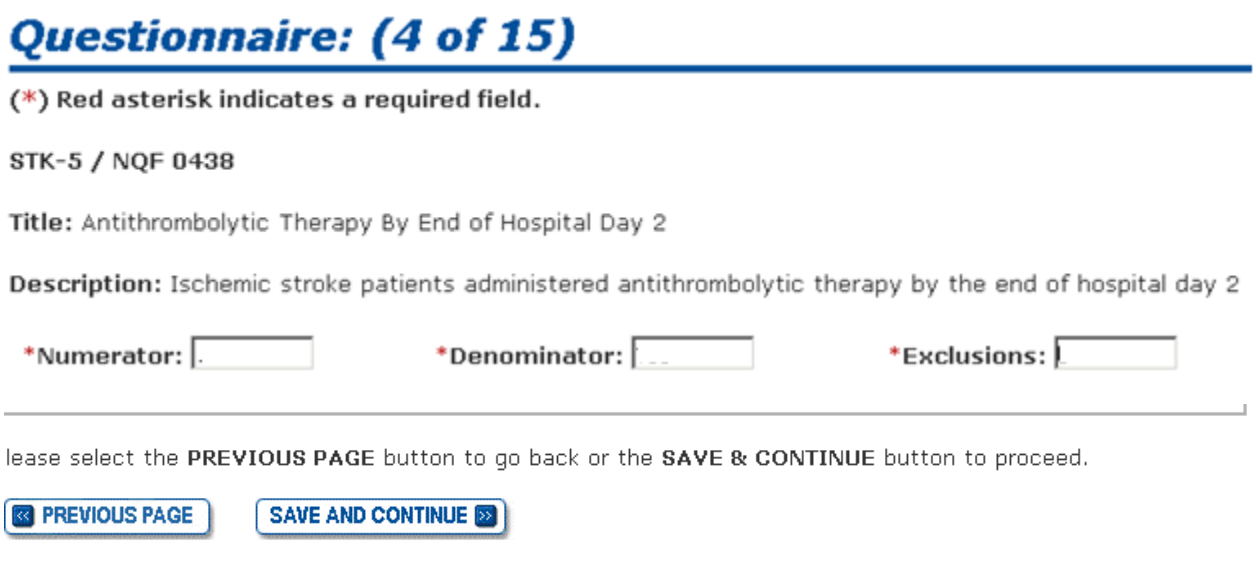
2013 Clinical Quality Measures Question 3



Questionnaire: (4 of 15)

(*) Red asterisk indicates a required field.

STK-5 / NQF 0438

Title: Antithrombolytic Therapy By End of Hospital Day 2

Description: Ischemic stroke patients administered antithrombolytic therapy by the end of hospital day 2

*Numerator: *Denominator: *Exclusions:

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2013 Clinical Quality Measures Question 4

Questionnaire: (5 of 15)

(*) Red asterisk indicates a required field.

STK-6 / NQF 0439

Title: Discharged on Statin Medication

Description: Ischemic stroke patients with LDL >= 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.

*Numerator: *Denominator: *Exclusions:

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2013 Clinical Quality Measures Question 5

Questionnaire: (6 of 15)

(*) Red asterisk indicates a required field.

STK-8 / NQF 0440

Title: Stroke Education

Description: Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke

*Numerator: *Denominator: *Exclusions:

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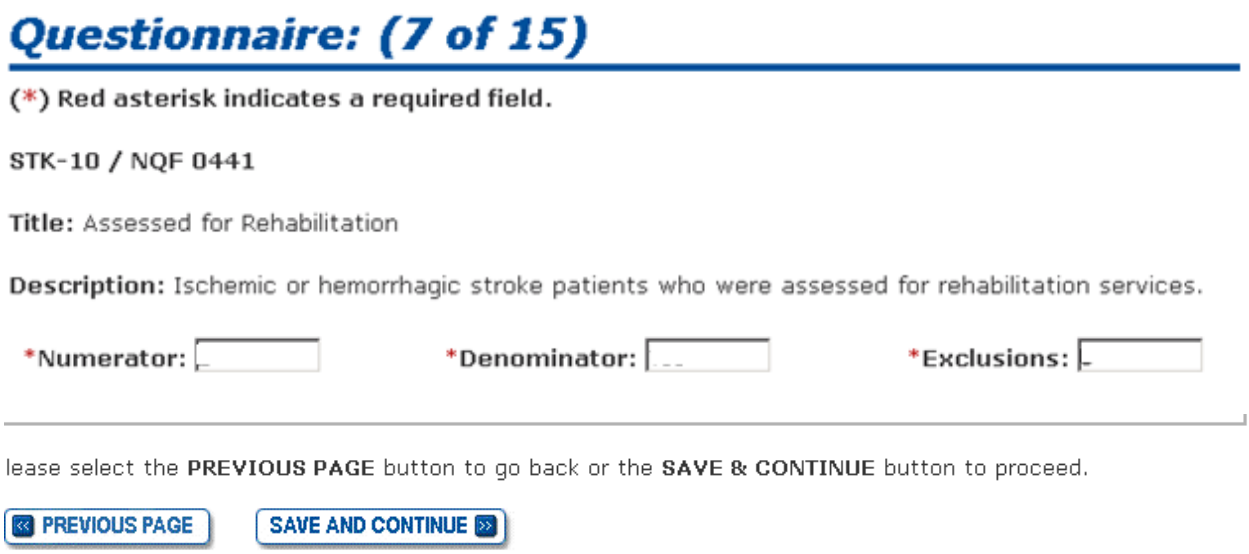
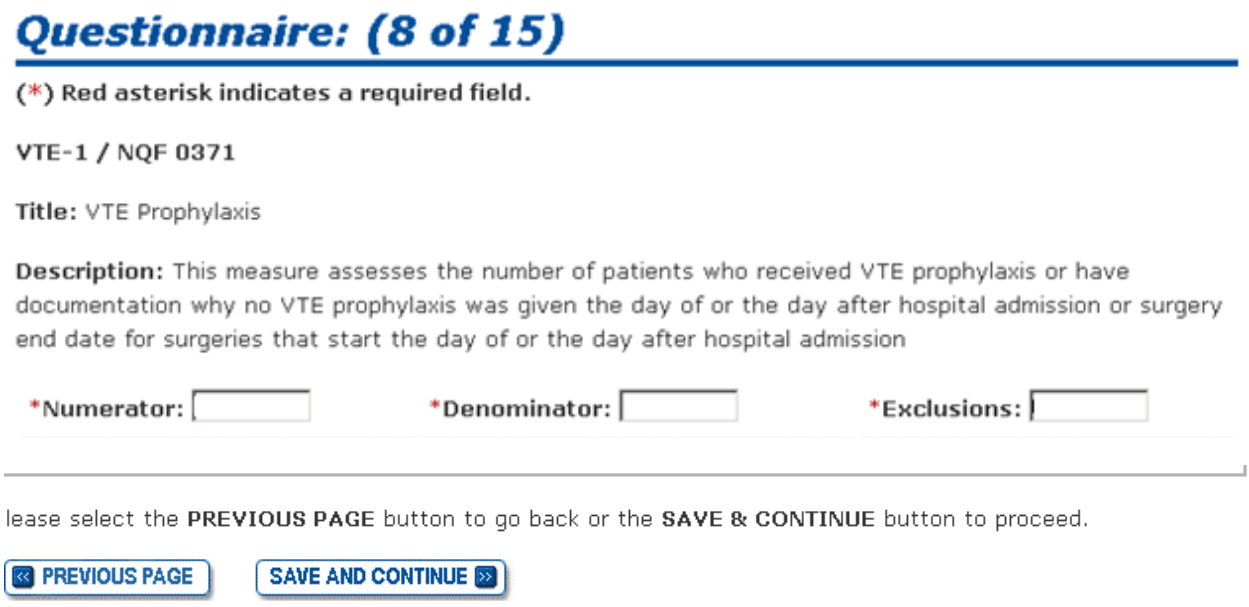
2013 Clinical Quality Measures Question 6



2013 Clinical Quality Measures Question 7



2013 Clinical Quality Measures Question 8

Questionnaire: (9 of 15)

(*) Red asterisk indicates a required field.

VTE-2 / NQF 0372

Title: Intensive Care Unit (ICU) VTE Prophylaxis

Description: This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)

*Numerator: *Denominator: *Exclusions:

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2013 Clinical Quality Measures Question 9

Questionnaire: (10 of 15)

(*) Red asterisk indicates a required field.

VTE-3 / NQF 0373

Title: Venous Thromboembolism (VTE) Patients with Anticoagulation Overlap Therapy

Description: This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) >= 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications

*Numerator: *Denominator: *Exclusions:

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2013 Clinical Quality Measures Question 10

Questionnaire: (11 of 15)

(*) Red asterisk indicates a required field.

VTE-4 / NQF 0374

Title: Venous Thromboembolism (VTE) Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)

Description: This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol

*Numerator: *Denominator: *Exclusions:

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2013 Clinical Quality Measures Question 11

Questionnaire: (12 of 15)

(*) Red asterisk indicates a required field.

VTE-5 / NQF 0375

Title: Venous Thromboembolism Discharge Instructions

Description: This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health or home hospice on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring and information about the potential for adverse drug reactions/interactions

*Numerator: *Denominator: *Exclusions:

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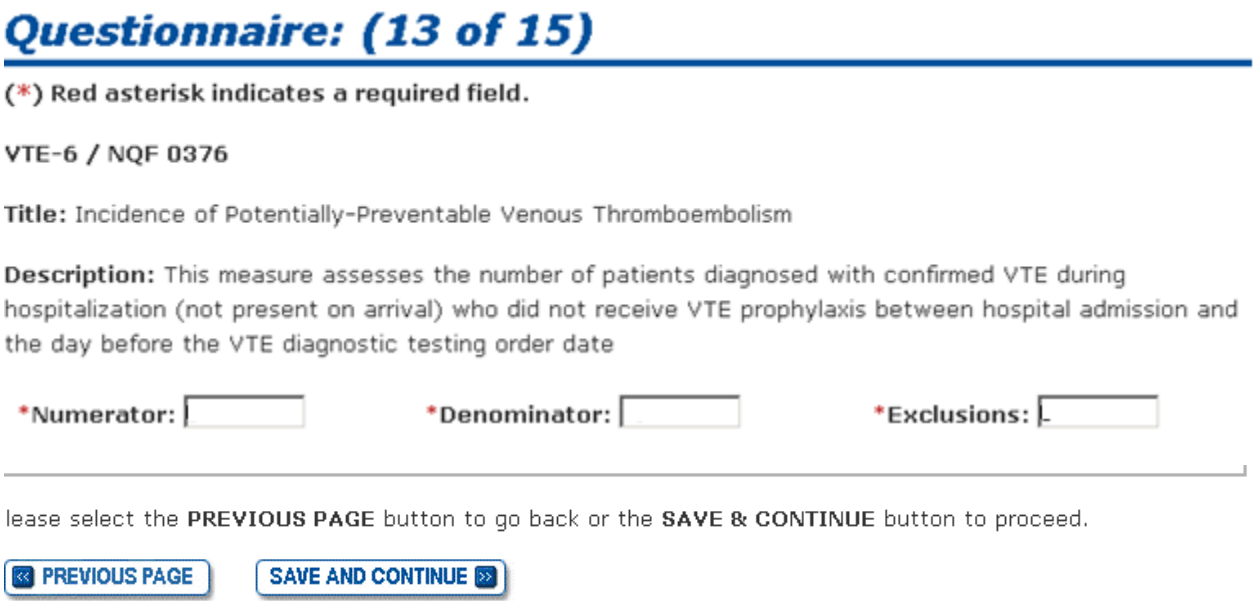
2013 Clinical Quality Measures Question 12



Questionnaire: (13 of 15)

(*) Red asterisk indicates a required field.

VTE-6 / NQF 0376

Title: Incidence of Potentially-Preventable Venous Thromboembolism

Description: This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date

*Numerator: *Denominator: *Exclusions:

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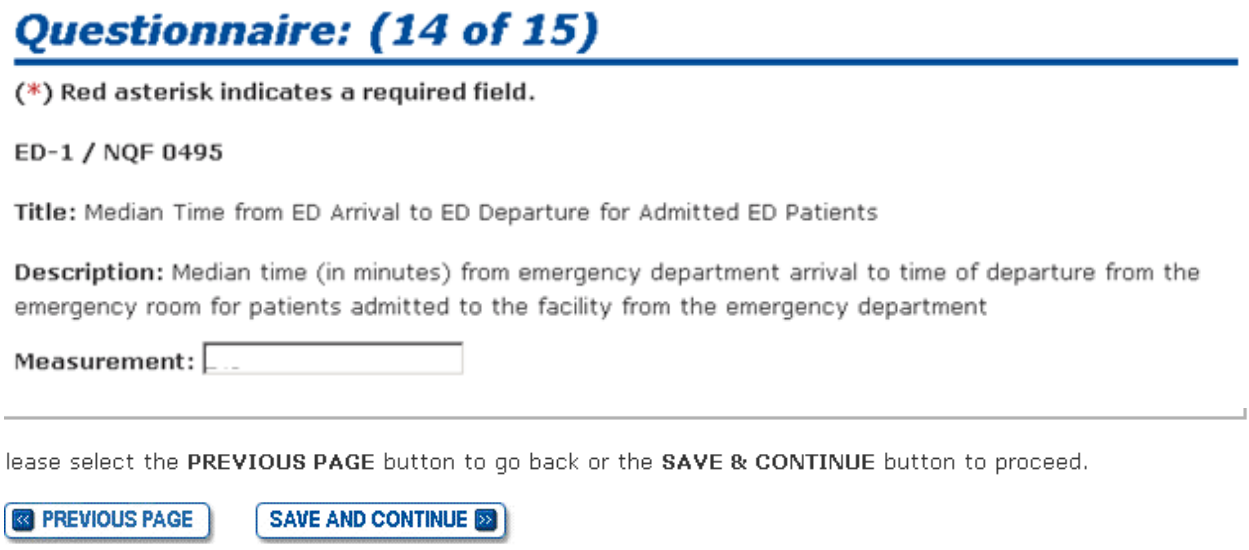
2013 Clinical Quality Measures Question 13



Questionnaire: (14 of 15)

(*) Red asterisk indicates a required field.

ED-1 / NQF 0495

Title: Median Time from ED Arrival to ED Departure for Admitted ED Patients

Description: Median time (in minutes) from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

Measurement:

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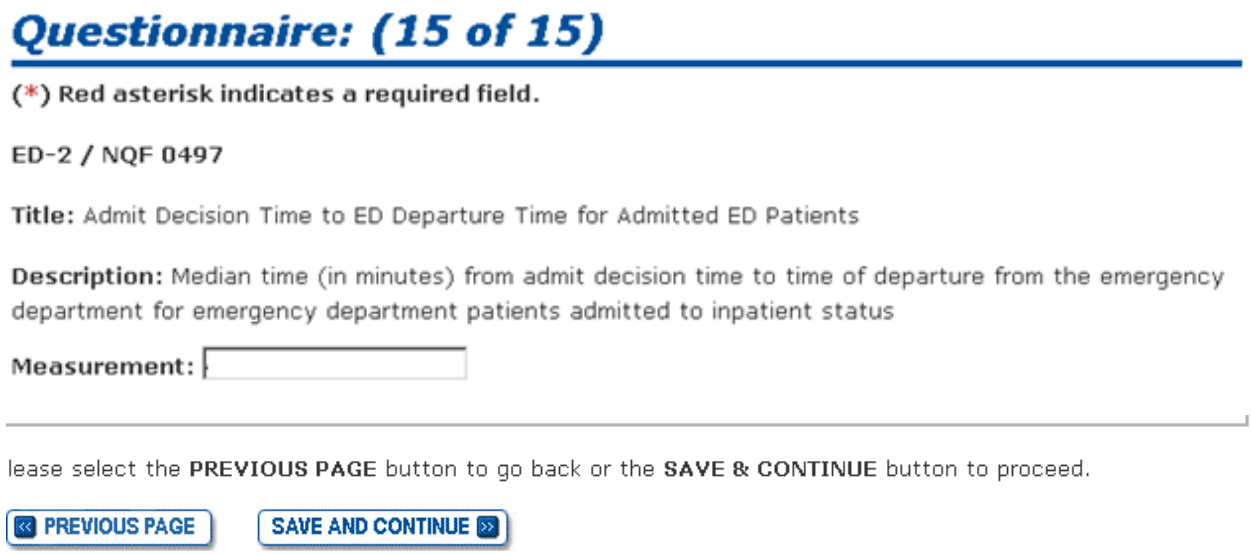
2013 Clinical Quality Measures Question 14



2013 Clinical Quality Measures Question 15